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DAVIS VISION™

THE EYECARE ADVANTAGE

www.davisvision.com

SECTION I
WELCOME TO DAVIS VISION

The Davis Vision Plan

Since 1964, Davis Vision, a wholly owned subsidiary of Highmark, Inc., has played a major role in providing quality vision care services. Davis Vision is distinguished from virtually every other vision care plan by its central laboratories, administrative systems, paid-in-full benefits and a professional quality improvement program.

Davis Vision provides vision care to managed care organizations (HMOs and PPOs), insurance companies, governmental groups, corporations, union trust funds and third party administrators. Represented in every state, the District of Columbia and Puerto Rico, the Davis Vision Plan brings together patients with highly qualified eye care professionals.

Participants eligible to receive benefits from a Davis Vision program receive descriptive information on the vision services. Members may select a provider simply by logging onto the web site (**www.davisvision.com**), calling the Interactive Voice Response System, or speaking directly to a Member Service Representative and requesting a customized list of local providers.

Davis Vision is committed to providing excellence in service to its' network of providers, clients and patients. **"WHATEVER IT TAKES"** is the Davis Vision corporate culture by which 100% delight is ensured. Davis Vision continuously strives to render quality products and services.

The quest for excellence involves each provider's practice. The relationship between Davis Vision and the provider is a partnership that is dependent upon the quality of care rendered by the provider, as well as the services Davis Vision provides. Together they provide vision care services to over thirty-five million plan participants nationwide. Support of Davis Vision programs lends a great value to both the provider and the patients receiving service from their practice.

PROVIDER AGREEMENT

The provider agrees to deliver quality professional care to covered participants of the Vision Care Plan and adhere to the Standards of Care and protocols contained herein. Appropriate tests and treatments will be provided and referrals will be made to meet the visual, ocular and health needs of persons receiving care under this plan. The Vision Care Plan Frame Collection (if applicable) will be shown to all persons receiving eyeglasses under the Plan. Provider facilities and records will be available for review upon request by designated representatives of the Plan.

The provider agrees to accept the Plan's scheduled fees as payment in full (except for applicable co-payments) for the eye examination and dispensing of lenses and frames or fitting of contact lenses provided by the central laboratory. The client-specific fees will be applied for all billing, laboratory orders and allowances for non-plan items. The provider agrees not to assert any patient charge for covered items except for applicable co-payments or allowable amounts.

All doctors must submit either a signed standard Participating Provider Agreement or state-specific agreement where applicable (appended as Attachment "1" inclusive). Doctors must enroll all licensed professional associates providing covered services to beneficiaries by the completion of the "Practitioner Information" section (Attachment "2") found within the provider application packet. Certain states may require that a specific uniform credentialing form be used as adopted through local regulation instead of the Davis Vision form. Davis Vision will accept these state-specific credentialing forms in lieu of its own application, if applicable, while still requesting further information/documentation not mentioned on those forms if necessary, and if allowable, by law.

All participating providers agree to abide by the following prime characteristics of the Plan:

1. Provider agrees to provide an eye examination including, but not limited to, visual acuities, internal and external ocular examinations (including dilation where professionally indicated), refraction, binocular function testing, tonometry, neurological integrity, biomicroscopy, keratometry, diagnosis and treatment plan and (when authorized by state law and covered by a Plan) medical eye care, diagnosis, treatment and eye care management services, and ordering and dispensing plan eyeglasses or contact lenses according to Plan protocols.

2. Provider agrees to observe the standards of care, quality improvement and grievance resolution protocols as set forth in this Vision Care Plan Provider Manual.

3. Provider agrees to prepare and maintain patient records consistent with generally accepted standards and the requirements of Davis Vision. Copies of the Plan Vision Care Service Record Form will be completed for each individual to whom services are rendered, signed by both the doctor and the patient, and retained for a period of not less than ten (10) years (or per statutory/federal requirement, whichever is greater).

4. Provider agrees to accept the Plan's fees as payment in full (except for applicable plan co-payments) for the eye examination and dispensing of lenses and frames or contact lenses provided by the central laboratory. The client-specific fees will be applied for all billing, laboratory orders and allowances for non-plan items. The provider agrees not to assert any patient charge for covered items except for applicable co-payments or allowable amounts.

5. Professional liability insurance will be maintained at a level equal to $1 million per occurence/$3 million annual aggregate or the community standard.

6. Provider agrees to maintain the Collection of Plan frames in accordance with the specifications in the Provider Agreement. Beneficiaries will be shown all suitable frame styles. The Collection, display, and other Plan materials will be returned to Davis Vision upon request.

7. No claim for compensation for any covered services will be made against any participant. The vision care plan fee, as designated in the Plan outline, will be accepted as payment in full for the eye examination and dispensing of Plan lenses and frames, except when Plan co-payments apply.

8. A courtesy discount of at least 20% off the provider's usual and customary fees (or 10% off for disposable contact lenses) will be extended to Plan beneficiaries for the purchase of materials not covered by the Plan.

9. Eligibility will be verified by contacting Davis Vision via a toll-free telephone number, on-line via Davis Vision's web site (**www.davisvision.com**), by toll-free fax or by receipt of a valid service voucher.

10. Providers agrees to indemnify and hold Davis Vision and its clients harmless from any damages or legal action arising out of the services provided under the terms and conditions of the Provider Agreement.

11. Provider agrees to submit and maintain on file with Davis Vision a completed application, copies of their current state and DEA licenses, board certification and current malpractice policies, among other items.

12. Provider will maintain in good standing all licenses required by law and must notify Davis Vision immediately of any action, which may adversely affect continuation of any applicable licenses. The provider must also notify Davis Vision of any pending malpractice claims or settlements made against them.

13. Provider agrees to allow Davis Vision to conduct on-site office visitations and patient record reviews.

14. Provider agrees to abide by the protocols and standards detailed in this manual.

PROFESSIONAL ETHICS

As a provider of vision care, Davis Vision promotes the guidelines of ethical behavior established by the American Optometric Association and the American Academy of Ophthalmology. In conjunction with our Integrity Process, these guidelines give Davis Vision's panel providers an understanding of the ethical behavior expected. All decisions regarding treatment will be determined solely on medical necessity and not on financial cost. The following guidelines are given prominence:

1. To hold the physical, emotional, social, health and visual welfare of all Davis Vision members uppermost at all times.
2. To ensure better care and services, and to provide these services with compassion, honesty, integrity and respect for the member's dignity.
3. To promote and hold in professional confidence all information concerning a patient, to use such information for the benefit of the patient, and to abide by all federal, state, and local regulatory agencies in maintaining this confidentiality.
4. To continually maintain and improve one's competency which includes technical ability, cognitive knowledge and ethical concerns for the member. Competence involves having the most current knowledge and understanding of vision care, enabling providers to make professionally appropriate and acceptable decisions in managing a member's care.
5. To provide care and services appropriate to the degree of education and training.
6. To consult with other health care professionals and refer patients, when appropriate.
7. To uphold the Davis Vision Patient's Bill of Rights. To obtain informed consent for all treatment, procedures and services. To communicate and educate patients and/or appropriate family members.
8. To inform Davis Vision of any impairment, physically, mentally or emotionally, that may impede one's ability to provide appropriate patient care or to meet contractual obligations with Davis Vision.
9. To conduct oneself in an ethical and professional manner as described by the appropriate professional association and to comply with all federal, state and local regulations relating to the practice of one's profession.
10. To communicate with all members at an appropriate level of comprehension and/or in a language understood by the member or refer the member to Davis Vision for translation services.
11. To involve member and/or family members, when appropriate, in all treatment plans and decisions.
12. To resolve all conflicts involving treatment plans or, if unable to do so, to refer the member to Davis Vision, their applicable Plan or appropriate state agency for resolution.
13. To inform members of their right to view the policy and procedures for conflict resolution by contacting Davis Vision, their applicable Plan or appropriate state agency directly.

PROVIDER BILL OF RIGHTS

1. *Providers have the right* to compensation and payment for authorized services provided to all Davis Vision members within sixty (60) days for all accurately completed claims.
2. *Providers have the right* to request prompt payment of all co-payments and/or deductibles from all Davis Vision members.

3. *Providers have the right* to request a copy of any document required by a contracting Plan, which has been approved by Davis Vision and requires a provider's signature.

4. *Providers have the right* to know that composition of the Utilization Review and Quality Management Committees include panel providers whenever appropriate. Providers have the right to provide feedback to Davis Vision on standards of care and clinical practice guidelines utilized by Davis Vision.

5. *Providers have the right* to voice any grievance on behalf of members or themselves regarding covered services.

6. *Providers have the right* to appeal decisions of Davis Vision without fear of reprisal.

7. *Providers have the right* to confidentiality of all credentialing information, subject to applicable local or state law as per the Participating Provider Agreement. Providers have the right to request access to their credentialing file to review information collected, to correct any erroneous information obtained during the credentialing process and to be informed of their status.

8. *Providers have the right* to confidentiality of their compensation arrangement with Davis Vision.

9. *Providers have the right* to discuss all treatment options regardless of restrictions imposed by the vision care plan.

10. *Providers have the right* to prescribe, refer, and/or manage the care of patients based on their professional experience and judgment.

11. *Providers have the right* to receive all information needed to understand the benefit plans of members in their geographic area.

12. *Providers have the right* to know the qualifications of peers whose recommendations and/or decisions may differ from theirs or may affect their membership on the Davis Vision panel.

13. *Providers have the right* to make recommendations regarding quality of care, standards of care or clinical practice guidelines adopted or adapted by Davis Vision.

14. *Providers have the right* to be treated with respect and dignity regardless of their race, color, religion, sex, age national origin, disability or sexual orientation.

PROVIDER RESPONSIBILITIES

1. Providers are responsible to provide all medically appropriate covered services to participants within the scope of their license and to treat, manage, coordinate and monitor such care to each member.

2. Providers are responsible to maintain a service record and/or treatment record form for each member and to complete each form in accordance with Davis Vision's policy. Provider will hold such information confidential.

3. Providers may not differentiate or discriminate in the treatment of Davis Vision members as to the quality of service delivered because of race, sex, marital status, veteran status, age, religion, color, creed, sexual orientation, national origin, disability, place of residence or health status. Providers will protect the rights of Davis Vision members. (See Section VIII for details on the Patient Bill of Rights.)

4. Providers are responsible to be available to provide services to Davis Vision's members for medically appropriate urgent care. Information and instructions regarding emergency care shall be available twenty-four (24) hours per day, seven (7) days per week.

5. Providers are responsible to maintain malpractice insurance in the amount of one million dollars ($1,000,000.00) per occurrence and three million dollars ($3,000,000.00) in the annual aggregate to cover any loss or liability.

6. Providers are responsible to comply with all credentialing and recredentialing requests in a timely manner.

7. Providers are responsible to notify Davis Vision immediately if their license has been suspended, restricted or limited in any way.

8. Providers are responsible to comply with all applicable federal, state or municipal statutes or ordinances and all applicable rules and regulations and the ethical standards of the appropriate professional society.

9. Providers are responsible to comply with all policies and procedures as described in the Provider Manual. Providers are responsible to maintain confidentiality of financial information from other providers but may discuss financial arrangements with Davis Vision's members.

10. Providers are responsible to comply with all utilization and quality improvement programs of Davis Vision and to submit requested documentation in a timely manner.

11. Providers are responsible for verifying Davis Vision's members' eligibility and obtaining authorization.

12. Providers are responsible for submitting all claims within sixty (60) days of the date services were provided.

13. Providers are responsible to inform Davis Vision's members' of their financial responsibility prior to administering services.

14. Providers are responsible to inform Davis Vision when their offices will be closed for three (3) months or longer due to vacation, illness or other circumstances.

15. Providers are required to report any sentinel event.

SECTION II
THE VISION CARE BENEFIT

MANAGED CARE PLANS

Davis Vision contracts with Managed Care Plans (e.g., HMOs and PPOs) to provide basic vision care services for their members. In most instances, the vision benefit and procedure are the same as those of the other groups; however, in some instances, a particular program may have standardized protocols with which Davis Vision must conform.

It is important for Davis Vision providers to realize that many managed care patients obtain their comprehensive health care, including ophthalmologic services, through a designated HMO/PPO network. All specialty medical care may require approval by a Primary Care Physician (PCP). Each enrollee selects a PCP when they join an HMO. This is the "gatekeeper" system, which may apply to many specialty services (dermatology, orthopedics, etc.) and eye care. HMO/PPOs may be responsible for the reimbursement of such services unless the Primary Care Physician refers members in writing and authorizes the member to receive these services. Davis Vision participating providers must follow the protocol of the member's medical plan, including coordination of care with the PCP when appropriate, whenever rendering or recommending diagnostic or therapeutic medical eye care for services not covered under the Davis Vision Plan. Providers can obtain details of specific coverage by calling the Davis Vision eligibility number (800-77-DAVIS), logging on to our on-line interactive web site at **www.davisvision.com**, or calling our Interactive Voice Response System (also 800-77-DAVIS).

COVERED ITEMS

The basic vision care benefit consists of a routine eye examination and eyeglasses (lenses and frame) or contact lenses. Most client groups choose to provide the benefit once every twenty-four (24) months, but some groups provide it once every twelve (12) months. In addition, many groups allow annual benefits for children below a specified age.

Most groups limit coverage to one (1) pair of Plan eyeglasses (lenses and frame) or one pair of contact lenses. Some groups allow two (2) pairs of eyeglasses (Distance Vision and Near Vision) in lieu of bifocals. Others allow multiple pairs without restriction. Details of specific coverage will be provided for each group in the plan outline and Service Record Forms sent to your office. In most cases, the basic materials benefit includes:

- Almost every lens type
- All lens prescriptions
- Either plastic or glass lenses (for single vision, bifocal or trifocal)
- Oversized lenses

- All types of bifocals; however, the 25 or 28 mm. flat-top should be regarded as the standard bifocal whenever it can satisfy the patient's visual needs.
- Aphakic lenses (single vision and bifocal)
- Solid and gradient tinting of plastic lenses
- Contact lenses (in lieu of eyeglasses) (Plan Formularies are appended as Attachment "3".)
- Most plans cover non-cosmetic contact lenses for conditions such as Keratoconus.

NON-COVERED ITEMS

Standard examples of services and materials not included in the Plan are:

- Medical treatment of eye disease or injury
- Visual therapy
- Special lens designs or coatings other than those described in the benefit plan
- Replacement of lost/stolen eyewear
- Non-prescription (Plano) lenses
- Two pairs of eyeglasses in lieu of bifocals
- Services not performed by licensed personnel
- Low vision aids and services
- Prosthetic devices and services
- Materials and services not specified in the benefit design
- Contact lenses and eyeglasses in the same benefit period
- Insurance of contact lenses

Providers must inform members of all associated costs of non-covered items.

OPTIONAL ITEMS

Examples of services and materials groups may choose to include in their coverage (with or without co-payments) are:

- Premier Frames
- Plano Sunglasses
- Occupational Vision Program
- Additional Pairs of Spectacles
- Contact Lenses
- Progressive Addition Lenses (Standard and Premium) (Plan Formularies are appended as Attachment "3")
- Corning™ Photochromic (PGX) Lenses
- Scratch Resistant Coating
- Anti-Reflective Coating (ARC) (Plan Formularies are appended as Attachment "3")
- Hi-Index Lenses
- Polarized Lenses
- Polycarbonate Lenses (included for dependent children and monocular patients)
- Ultraviolet Coating
- Blended Segment Lenses
- Plastic Photosensitive Lenses
- Mirror Coated Lenses

If any of these items are included, information (along with any applicable co-payments) will be provided in the plan outline and on the Vision Care Service Record Form or service record/voucher.

NON-PLAN ALLOWANCES

Some groups make fixed payments (allowances) to doctors when patients select non-plan frames and/or contact lenses in lieu of Plan items. The amount of the Plan payment for each non-plan item will be provided. The allowance amount is to be subtracted from your usual and customary fee. The member may be responsible for a determined amount over the allowance according to the particular Plan specifications.

The benefit coverage for each patient is indicated on the Vision Care Service Record Form/voucher and in the plan outline. The coverage varies between groups and sometimes within a group, depending on patient type (member, spouse, child, retiree).

When a patient selects a non-plan frame, the provider will only receive one-half of the dispensing fees.

PATIENTS USING NETWORK DOCTORS

Eligible Davis Vision members wishing to use the Plan may obtain services from a network doctor. Members have the right to change providers for each eligibility period without notifying Davis Vision. An authorization number will be issued if their benefit has not been used during the eligibility period (usually 12 or 24 months). Authorizations are generally valid for a period of 45 days, but may vary according to plan criteria. Expired authorizations may be renewed pending eligibility status.

The full ophthalmic benefit is available at any network provider's office. Participants are advised that appointments are required.

There may be two important restrictions for participants:

1. Participants may be required to use the full benefit at one time and at one location. In these cases, the Plan will process only one claim per participant during the eligibility period.

2. If the Plan allows out-of-network (indemnity) usage, the benefit may or may not be split between an in-network provider and an out-of-network practitioner at the client's discretion.

PATIENTS USING AN OUT-OF-NETWORK OPTION

Some groups allow participants to use their benefit at non-participating offices (indemnity option). The patient pays out-of-pocket for services received and submits a completed Direct Reimbursement Claim form. Direct reimbursement is issued to the member (for services rendered to the patient, whether primary member or dependent) in accordance with a schedule of maximum fees.

Members are encouraged to use network providers (as opposed to the indemnity option) to maximize the value of their benefit beyond any indemnity amount they may receive when using out-of-network providers.

Davis Vision may accept claims from non-network providers submitted on behalf of patients, however payments are made directly to the patient except for specific plans.

OCCUPATIONAL VISION BENEFIT (OPTIONAL COVERAGE)

The Occupational Vision Benefit when offered by a sponsoring client is restricted to the employee **only**. The sponsoring client has the option to limit the eligibility to:

- All employees
- Particular job functions
- Specific employees

Occupational Vision Benefits are available only at Davis Vision provider offices and must be ordered through the provider's assigned Davis Vision regional laboratory.

Safety glasses meet ANSI Z.87 requirements. If used, glass lenses will be chemically hardened in accordance with FDA 21 CFR part 801. Providers are responsible for verifying eligibility and obtaining an authorization.

Three types of Occupational Benefits are offered:

STANDARD OCCUPATIONAL SAFETY BENEFIT

Members with the standard Occupational Safety Benefit are entitled to a routine eye examination and, at the provider's discretion, any additional testing required to determine the best-corrected visual acuity for the member. Members may choose a standard frame and a safety frame. Safety lens tinting is limited to gray or pink with a maximum density of 30% and may be ordered **only** in plastic. The members must place the order for the two sets of eyeglasses (dress pair and occupational pair) at the same time. Providers are to submit orders to their assigned Davis Vision regional laboratory.

STAND-ALONE OCCUPATIONAL BENEFIT

Members with a stand-alone Occupational Vision Benefit are entitled to **only** industrial eyeglasses. Members are entitled to a complete eye examination and, at the discretion of the provider, any additional testing required to achieve the best-corrected visual acuity for the member.

VIDEO DISPLAY TERMINAL (VDT)

The Video Display Terminal (VDT) benefit is limited to the employee **only**. The VDT benefit is available in conjunction with a standard vision benefit (i.e., "dress" pair). Providers must complete an examination including color vision testing, stereopsis and at the discretion of the provider any additional testing required to achieve the best-corrected visual acuity for the member. For a member to be eligible for the VDT eyeglass benefit the member's standard eyeglass prescription and the VDT prescription must differ in the following ways:

1. Prescription difference of at least 0.50 diopters
2. Different lens types, e.g. trifocal vs. bifocals
3. Segment height difference of at least 5mm

SECTION III
CONTACTING DAVIS VISION

DAVIS VISION'S WEB SITE

At Davis Vision, we are committed to developing and utilizing the newest, most sophisticated technologies, systems and programs to enhance patient care and provider interactions. One of the major areas of technology designed to further enhance our service is our on-line, interactive web site. Our address is **www.davisvision.com**.

As a network provider, you can more efficiently manage the tasks of submitting orders through one simple interface. If you have a connection to the Internet and a compatible web browser, you are a few mouse-clicks away from streamlining access to Davis Vision products and services. This service is available for Macintosh or PC users. To receive your password, please call an Internet Support Associate at **1-800-9HELP-DV (1-800-943-5738),** Monday – Friday, 8:00 AM to 6:00 PM ET.

The truly state-of-the-art proprietary software system allows on-line, real-time communication with provider offices and the ability to process eligibility information at the point-of-service. Through Internet connectivity, network providers have the ability to obtain, transmit, and exchange data and information much more quickly and efficiently.

ORDER MANAGEMENT MADE EASY

As a Davis Vision network provider, you can now authorize, submit, and track orders through a single easy-to-use web interface. Simply log on to **www.davisvision.com** and enter your provider number and password. You can then perform any of the following tasks:

VIEW BENEFIT PLANS

Display the current benefit information for a Davis Vision patient. You can display the plan benefits in several different formats or print out the information for later viewing.

OBTAIN AN AUTHORIZATION

Request an authorization for a plan participant that is currently eligible for services. You can display a list of all family members covered under the Plan and view their authorization history and eligibility status. If a family member is eligible, you may request an authorization. The system will verify your request and issue an authorization number for the services you may provide.

ENTER AN ORDER

Place an order for an examination, eyeglasses, spectacle lenses and/or contact lenses using our simple order entry screen that is designed for quick and efficient submission of orders.

TRACK AN ORDER

Obtain the status of an order based on the invoice number. Provider will also be able to display the status of all orders being processed at the Plainview laboratory.

ENTER AN EXCEL ADVANTAGE ORDER

Place an order using the Excel Advantage Program to choose from our selection of quality ophthalmic materials.

ORDER SERVICE RECORD FORMS

Easy-to-use method for obtaining forms.

VIEW THE PROVIDER MANUAL

Easy access to all sections and ***Attachments*** included in this manual.

PROVIDER PAYMENT PROCESS

Information regarding how the provider is reimbursed for professional services.

PROVIDER COMMUNICATION

News and opportunities for you to e-mail us or access the name of the Regional Quality Assurance Representative in your area.

The Davis Vision web site was designed to be user-friendly for all customers regardless of previous computer/Internet experience (in navigation or general computer applications). On-screen instructions are clear and easy to understand while the interface itself is intuitive and simple.

If challenges do arise, however, help is just a mouse-click away. An extensive Help utility is available that walks users through the application in a step-by-step manner. Users can also communicate directly with Davis Vision by sending questions through an easy-to-use e-mail interface, or, if preferred, they may place a call to our friendly customer service staff.

TELEPHONE AND WRITTEN COMMUNICATION

INTERACTIVE VOICE RESPONSE SYSTEM (IVR)

Providers have the option to contact Davis Vision using our IVR System. The IVR system may be accessed by calling **1-800-77DAVIS (1-800-773-2847)**. Providers are prompted to enter their provider number to gain access to the following capabilities:

- Verify member eligibility
- Obtain authorization
- Obtain benefit information
- Determine co-payments
- Request Service Record Forms
- Process claims for "Examination Only" services
- Place an order
- Order a remake of a previous order
- Track an order
- Obtain status of a claim
- Speak with a Member Service Representative

Providers may access the **IVR system 24 hours a day.** Member Service Representatives are available Monday through Friday 8:00 AM to 11:00 PM ET, Saturday 9:00 AM to 4:00 PM ET and Sunday 12:00 PM to 4:00 PM ET. Messages may be left after hours and will be returned the next business day.

CONTACT INFORMATION

Providers may also reach Davis Vision associates by telephone or mail. Contact Information for the most commonly requested areas of operation is appended as Attachment "4".

SECTION IV
FEES, ELIGIBILITY & AUTHORIZATION

EXAMINATION FEES

Examination fees are determined by geographic location and level of service to be provided to beneficiaries and client groups. Information regarding professional fees will be provided to your office through communication materials for each group plan in which you will be participating. Group-specific information will be provided on the group's plan outline.

DISPENSING FEES

Dispensing fees are determined based on geographic location and client group specifications. Dispensing fees will be provided to your office through communication materials for each group plan. Group-specific information will be provided on the group's plan outline.

SURFEES

Surfees (additional dispensing fees) may be provided when patients select specific options. When applicable, such fees will be specified on the Service Record Form and Plan Outline for each specific group.

CONTACT LENS FITTING FEE

Contact lens fitting fees are determined by the specific plan. When applicable, it will be noted on a group-specific plan outline in the communications sent to your office.

PATIENT CO-PAYMENTS

Applicable co-payments for each plan will be indicated on the vision care service record/vouchers, Service Record Forms and Plan Outlines provided to your office. Review this information carefully, as it is your responsibility to collect these co-payments. It is imperative that you record all plan co-payments received from patients on the Service Record Form or vision care service record/vouchers.

NON-PLAN ITEM REIMBURSEMENT

Some groups make fixed payments (allowances) to doctors when patients select non-plan frames or contact lenses in lieu of Plan supplied items. The allowance amount and provider reimbursement can be found on the group-specific Plan outline.

RECEIPTS

Patients are entitled to receipts for co-payments and the purchase of additional items. They may be needed for tax reports, reimbursement requirements from other health coverage or personal records. Receipts are not to be issued for the cost of services or materials included in the Plan.

COURTESY DISCOUNTS

The Plan requires that participating providers extend members a courtesy discount when purchasing items not covered in the basic benefit. The minimum courtesy discount is 20% off the provider's usual and customary fees (or 10% off for disposable contact lenses).

OUT-OF-AREA CARE

Health care services may be required outside of the service area due to emergencies and/or urgently needed services. If a member requires such care, the member or their designated representative should contact Davis Vision's Member Services or Quality Assurance/Patient Advocate Department for consideration. A designated committee will review the use and costs associated with these encounters. Reimbursement for any rendered services *not* covered by the benefit plan and/or services exceeding frequency limitations (within the specified benefit cycle) will be denied.

BENEFIT ABUSE

Whenever patients are suspected of misusing a plan benefit, the Utilization Review Committee will review all available data, and, if appropriate, contact the client.

ELIGIBILITY AND AUTHORIZATION

PAPERLESS PROGRAM

A paperless eligibility system has been developed which reduces paperwork and provides easy authorization and eligibility confirmation. Patients will be directed to call your office to arrange an appointment. At that time your office should obtain the member's name, member identification number and the date(s) of birth of each dependent for whom the appointments are being requested.

INTERACTIVE WEB SITE

If your office has Internet capability, you may log on to the easy-to-use Davis Vision web site at **www.davisvision.com** to access a variety of program services. The web site interfaces with Davis Vision's CompuVision™ system, allowing providers access to the following features upon entry of a valid provider number and password:

1. Request an immediate authorization for any plan participant who is currently eligible for services (available Monday through Friday from 8:00 AM to 11:00 PM ET, Saturday from 9:00 AM to 4:00 PM ET and Sunday from 12:00 PM to 4:00 PM ET).

2. Display a list of all family members covered under the Plan and view their authorization status and eligibility status. If a family member is eligible, you may elect to request an authorization. The system will verify your request and issue an authorization number for the services you may provide.

3. Obtain expanded benefit information for all Davis Vision patients, including examination co-payments and the "next day of eligibility" for currently ineligible patients.

4. Process claims for "eye examination **only**" services without having to speak with a Provider Service Representative.

5. Place prescription orders by following easy-to-use prompts.

6. Leave e-mail messages after hours. Return calls will be placed to your office the next business day.

7. Obtain a Personalized Service Record Form.

INTERACTIVE VOICE RESPONSE SYSTEM (IVR)

You may obtain immediate authorization and eligibility verification by placing a call to either the Interactive Voice Response (IVR) System or a Provider Service Representative. Authorizations are generally valid for 45 days, but may vary according to plan criteria. The authorization number should be recorded on the group Vision Care Service Record Form (Attachment "5").

Davis Vision's automated IVR enhances our Provider Service capabilities by providing authorization numbers, eligibility verification and authorization of service immediately. Calling Davis Vision at **1-800-77DAVIS** (1-800-773-2847) enables you to:

1. Obtain expanded benefit entitlement information for all Davis Vision patients, including examination co-payments and the "next day of eligibility" for currently ineligible patients.
2. Receive authorization numbers for multiple members (or family members), and information for previously issued authorization number(s) in less time.
3. Void or extend an authorization.
4. Process claims for "eye examination **only**" services without having to speak with a Provider Service Representative.
5. Request additional supplies of Service Record Forms.
6. Print a personalized Service Record Form (if applicable to that group).

The IVR's easy-to-follow menu enables you to quickly obtain needed information. A flowchart demonstrating the Interactive Voice Response system is appended as Attachment "6". Provider Service Representatives (PSRs) are available to provide assistance Monday through Friday, 8:00 AM to 11:00 PM ET, Saturday 9:00 AM to 4:00 PM ET and Sunday 12:00 PM to 4:00 PM ET by calling **1-800-77DAVIS**.

PAPER/VOUCHER PROGRAM

SERVICE RECORD/VOUCHER PROGRAM ELIGIBILITY

Network providers are *not* responsible for determining eligibility in a Voucher Program. Only eligible persons receive vision benefit service record/vouchers. Plan services should be provided only to the person named on the service record/voucher.

The benefit coverage for each member is indicated at the top of the service record/voucher in the Benefit Key section. The coverage varies between groups and sometimes within a group depending on patient type (member, spouse, child, retiree).

Provider offices are responsible for verifying that service record/vouchers have not expired. The expiration date of the service record/voucher is generally indicated at the top of the service record/voucher. Members whose service record/vouchers have expired are responsible to obtain a current one.

The major characteristics of the service record/voucher program are:

1. Only one service code is required on the service record/voucher claim form for each pair of eyeglasses provided by the Plan. A listing of all codes is appended as Attachment "7".

2. If allowed, members may receive the network (plan-provided) eye examination and still select non-plan frames or contact lenses. The patient pays charges for non-plan items, less any Plan allowance. Specific Plan allowances are found on group-specific service record/vouchers in the Benefit Key Section.

3. Fees and benefit levels may vary somewhat among groups due to contract periods, customary fee levels and coverage in the region. The Benefit Key at the top of all service record/vouchers contains the most current coverage and benefit information. It is specific to the patient whose name appears on the service record/voucher.

SECTION V
BILLING AND CLAIMS

ORDER ENTRY AND CLAIMS PROCESSING

All Davis Vision providers have options for submitting orders and claims or "examination only" orders. Davis Vision's **paperless program** allows order entry and claims processing to occur simultaneously. Providers with Internet capabilities who log onto to our web site, **www.davisvision.com**, can conveniently accomplish both tasks.

All claims and/or orders must be faxed, telephoned, mailed or e-mailed to Davis Vision for payment.

WEB SITE (www.davisvision.com)

The Davis Vision web site now offers two methods for placing your orders. The preferred method, **ENTER ORDERS**, allows providers to interact directly with Davis Vision's CompuVision™ system. Davis Vision assures 100% accuracy in the order entry and will issue an invoice number for your order upon completion. Providers simply log on to our web site at **www.davisvision.com** and enter their provider number and password, then follow our simple order entry screens to submit orders for examinations, eyeglasses and/or contact lenses.

The second method called **2 CLICK FAST ORDER ENTRY** provides you with an on-line order form that you complete and then e-mail back to Davis Vision at **www.davisvision.com**. A Davis Vision representative will enter the order, then e-mail an invoice confirmation to you within twenty-four hours.

INTERACTIVE VOICE RESPONSE (IVR)

Claims for **examination only** services (no materials), may be processed through the IVR system by calling **1-800-77DAVIS (1-800-773-2847)**. The IVR will prompt you through the appropriate steps.

PAPER/VOUCHER SYSTEM

FAX ORDER ENTRY

Davis Vision has a dedicated Fax Order Entry System that can be utilized by providers who do not have Internet access and those client groups who have a Voucher Program (i.e., require service records/vouchers for members who wish to utilize their Davis Vision benefit). Providers may fax orders to 1-800-933-9375 (1-800-93-EYES-5). All faxed orders must be accompanied by a Davis Vision Fax Cover Sheet and Laboratory Order Form. Upon receipt of the Laboratory Order Form, the information is entered into CompuVision™. The FAXGATE system will automatically fax back the cover sheet with an invoice number confirming the order. The Fax Order Entry System turnaround time is twenty-four (24) to forty-eight (48) hours from receipt of the order. Fax Laboratory Order Forms are available upon request.

LENS ONLY ORDERS

"Lens Only" orders can be placed in the same manner you would place complete pair orders (via the Davis Vision web site, e-mail, IVR or Fax Order Entry); however, for such orders, you **must** indicate that the patient's frame is to follow.

SERVICE RECORD/VOUCHER CLAIMS

When required by the Plan, providers must submit the original service record/voucher and retain a copy for office records. No other correspondence should be submitted with the service record/vouchers. Please **do not mail** laboratory orders with the service record/vouchers. If return of the service record/voucher is not required by the Plan, it must be retained in your office for ten (10) years or in accordance with state or federal statute, whichever is greater.

When it is required that the original service record/voucher be submitted for payment, submission should occur *after* the examination has been provided and the eyeglasses have been ordered. The following address should be used:

Vision Care Plan Processing Unit
P.O. Box 1525
Latham, New York 12110

BILLING CLAIM FORMS

PAPERLESS SYSTEM

VISION CARE SERVICE RECORD FORM COMPLETION

Group-specific Vision Care Service Record Forms, which have been provided to your office, should be completed for each eligible member served. The following instructions are provided to guide you in completion of each section of the form.

SECTION I: PROVIDER/PATIENT SECTION

1. The member's name and identification number must be obtained. If the patient receiving services is *not* the member, you must determine the relationship to the member (e.g., spouse, dependent, etc.), and enter the date of birth. This information should be obtained when the appointment is made.

2. Provider name and Davis Vision-assigned Provider Number.

SECTION II: COVERAGE

1. Insert authorization number obtained from Davis Vision.

SECTION III: SERVICE

1. Indicate whether or not an examination was performed. If an examination was performed, indicate whether dilation was performed.

2. Indicate lens type and specifications.

3. Indicate type of frame selected: Plan frame (from Plan Collection), non-plan frame (from provider's inventory) or patient's own frame.

4. Indicate options dispensed.

5. Indicate diagnosis code(s).

6. If any other service is provided, please add this information in the designated area.

SECTION IV: ALLOWANCE

1. This is an informational section for the doctor and patient and does not require completion by the doctor.

2. The allowance amount and provider reimbursement can be found on the group-specific Plan outline.

SECTION V: OPTIONS

1. This section indicates the fees to be paid by the patient for each of the options available.

2. The fees are provided for each Plan level, when applicable.

3. Professional surfees for additional dispensing are also listed.

SECTION VI: SIGNATURE

1. This section **must** be completed by the patient (or guardian when patient is a minor) to verify that the provider has performed the services for which reimbursement has been submitted.

2. The provider must date and sign the form and indicate that services have been rendered.

The provider will retain the completed form for a period of at least ten (10) years (or statutory requirement), and make it available for review upon request.

VOUCHER SYSTEM

SERVICE RECORD/VOUCHER COMPLETION

Refer to the sample service record/voucher Claim Form (Attachment "8") and the corresponding explanation/instructions that follow. **It is essential that the form be filled out accurately and completely.**

HEADER INFORMATION

The upper portion of the form is automatically printed by the computer or may be issued by the group. The information is self-explanatory. Only the person designated as the patient can use the service record/voucher. Another person may not use the service record/voucher and the name may not be changed.

The service record/voucher is redeemable by the provider for services rendered only prior to or *on* the indicated expiration date. If a member has an expired service record/voucher, the member should request an extension by calling Member Services at 1-800-999-5431.

BENEFIT KEY

The Benefit Key indicates a patient's coverage. It gives the benefit coverage, co-payments and allowances for non-plan items. The Benefit Key is specific for the service record/voucher holder.

If an item is not available, the notation "NA" will print.

If an item is covered, the co-payment amount (to be collected by your office directly from the patient) is noted. If there is no co-payment and the item is covered, the notation "00" will print. Special coverage and limitations are noted in the "OTHER" and "PLEASE NOTE" boxes of the Benefit Key.

MEMBER'S SIGNATURE AND DATE

The member or eligible dependent (or guardian for dependent children) is required to sign and date the service record/voucher before it is submitted for payment.

FOR PLAN USE

The section headed "FOR PROVIDER AND CLAIMS PROCESSING UNIT USE ONLY" is the portion that participating providers are to complete for billing purposes.

PLAN PROVIDER NUMBER

Enter the Davis Vision provider number assigned to you for the location where services were rendered along with the three-digit identifier for the actual servicing practitioner.

SERVICE CODE

Enter the appropriate code from the Service Code Table (Attachment "7").

The following protocols should be used in billing for additional services.

ADDITIONAL PAIRS

Use multiple codes in service code box, e.g., 002, N05 ("N" indicates no exam with second pair dispensing). Please refer to Attachment "7" for Prefix and Suffix codes.

PHOTO GREY EXTRA (PGX)

Use a "P" suffix to service code, e.g., 002-P or 005-P.

INVISIBLE BIFOCALS

Standard Invisible Bifocal – Use an "I" suffix to service code, e.g., 005-I.
Blended Bifocal – Use an "E" suffix code, e.g., 005-E.
Premium Invisible Progressive Bifocal – Use "@" suffix code, e.g. 005-@.

PREMIER FRAMES

Use an "F" prefix to service code (e.g., F-002) to indicate selection of a Premier frame. When applicable, use the appropriate suffix code(s) when other options are requested (e.g. the code "F-005-P" indicates selection of a Premier Frame and Photo Grey Extra).

OCCUPATIONAL (When in conjunction with standard vision care benefit)

If an occupational examination is provided and no need exists for special occupational eyeglasses, the provider enters the appropriate service code with an "OE" prefix, e.g., OE-001or OE-005.

If an occupational examination reveals a need for separate occupational eyeglasses, the provider enters two service codes. The first is the code for the conventional eyeglasses, but with an "OG" prefix, e.g., OG-002. The second is for the occupational glasses and has an "N" as the first character (no exam), e.g., N05. Typical billings would be OG-005, N02; or OG-005, N05; or OG-002, N02.

SERVICE DATE

Indicate in two (2) digit numbers the month, day and year on which the examination was provided; e.g., 01/02/00.

SIGNATURE

The participating provider who performs the examination must sign the form.

CLAIMS

Davis Vision generally captures all claim information automatically when an accurately completed order for eyeglasses or contacts is received regardless of the **order entry** method utilized by the provider's office.

PROMPT PAYMENT AND CLEAN CLAIMS POLICIES

IN-NETWORK CLAIMS

Davis Vision shall make payment within thirty (30) days of receipt of all electronic "clean claims" and shall make payment within forty (40) days of receipt of the clean claim where the claim is submitted by other than electronic means.

A clean in-network claim is defined as having the following:

- A valid authorization number, referencing member and patient information
- A valid Davis Vision assigned provider number
- The date of service
- The primary diagnosis code
- An indication as to whether or not dilation was performed
- A description of services provided (examination, materials, etc.)
- All necessary prescription eyewear order information (if applicable)

Provider will bill Davis Vision for all covered services rendered to a participant, less any co-payment and deductible collected or to be collected from the participant. Providers shall submit to Davis Vision a statement (written, electronic or verbal, as approved as to form and content by Davis) for all covered services rendered by the provider within sixty (60) days following the provision of covered services. Failure to submit statement within sixty (60) days of service delivery will, at Davis Vision's option, result in non-payment by Payer to the provider for the covered services rendered. If provider is indebted to Davis Vision for any reason including, but not limited to, erroneous claim payments or payments due for materials and supplies, Davis Vision may offset such indebtedness against any compensation due to Provider pursuant to the Participating Provider Agreement appended as Attachment "1", or otherwise as required by state law.

All action dates are clearly shown on the voucher screen (claim screen) in CompuVision™, including the authorization date, the authorization expiration date, the process date (order or claim date), the date the check is produced (register date), and the date of service. All claims are adjudicated immediately upon receipt from the provider. Also, when an adjustment is made to a claim, a new voucher record (claim record) is produced showing all new information. This voucher screen also has a field for documentation of the adjustment, which is utilized by Davis Vision to document any new information about the claim. Should Davis Vision fail to pay a clean claim within the time limits set forth above, Davis Vision shall include simple interest on the claim amount at the rate of ten percent (10%) per year and will either add the interest amount to the claim amount when paying the claim or issue an interest payment within fourteen (14) days of the payment of the claim. Interest shall accrue beginning thirty (30) or forty (40) days, as applicable, from the date all information and documentation required to process the claim is received by Davis Vision. With provider's consent, Davis Vision may aggregate interest amounts under a dollar.

If, however, a system fault or other delay causes a claim or claims to be delayed beyond the thirty (30) day period, Davis Vision will pay the required interest based on the claim amount as calculated from the time claim should have been paid.

Participating providers submit all in-network claims. Patients are not responsible for submitting claims when receiving services and/or materials from in-network providers.

OUT-OF-NETWORK CLAIMS

Out-of-network claims are processed upon receipt. "Clean claims" are either denied within 7 days or paid within 7-23 days.

A clean out-of-network claim is defined as having the following:

- A valid policyholder ID
- A valid Davis Vision provider number, if the benefit is assigned
- Patient name
- Date of service
- Itemized charges
- Signature of the policyholder

Once a request for additional information has been made to members submitting "unclean" claims (within 7-23 days), the claim is pended until the receipt of requested information from the member. As a result, late claims and interest are not applicable. If however, a system fault or other delay causes a claim or claims to be delayed, Davis Vision will pay the required interest based on the claim amount as calculated from the time the claim should have been paid.

Members are responsible to submit all out-of-network claims. Members cannot assign payments to an out-of-network provider. Non-participating practitioners are not responsible for submitting claims when rendering services and/or materials to covered members.

SECTION VI
OPHTHALMIC MATERIALS AND LABORATORIES

SAMPLE FRAME COLLECTION

Davis Vision features a standardized Plan Collection of frames at all dispensing locations. All panel offices receive the frame collection prior to participation in the program (when applicable). Davis Vision supplies a modern, stylish and compact frame display that contains samples of plan frames.

All Frames have color-coded tags which allow you to easily determine the appropriate frames to which the member is entitled. It is important to keep the color-coded tags on the frames as they indicate the frame collection level. The frame collection is tagged as follows:

Benefit Level	Color Code
Value	Green Tag, if applicable
Fashion	Gold Tag
Designer	Red or Pink Tag
Premier	Blue Tag
Safety	No Tag

The cost of the sample frame collection and display is assumed by Davis Vision and remains the property of Davis Vision. Davis Vision retains the right to take possession of the Collection when a provider ceases to participate with the Plan and, with reasonable notice, at any other time. Providers assume full responsibility for the cost of any missing frames and will be required to reimburse the Plan for missing and unaccounted frames.

Frames supplied meet all standards outlined under the American National Standards Institute ANSI Z.80.5-1979.

LENSES

Only first quality lenses are supplied under the plans. All lenses are provided and workmanship performed in accordance with the American National Standards Institute ANSI Z80.1-1979. Glass ophthalmic lenses are chemically strengthened to achieve impact resistance in accordance with FDA Regulations 21CFR, Sub Part H, Section 801.410. All finished materials are quality assured prior to shipping.

Polycarbonate lenses are provided *at no extra cost* to all eligible dependent children (as defined by the Plan) and to those beneficiaries who are sighted in only one eye (i.e., monocular patients) without additional dispensing fee to the provider. This policy is intended to provide maximum impact resistance and prevention of eye injuries for all eligible children and monocular patients requiring prescription eyewear.

CONTACT LENSES

To ensure maximum value for members, distinction may be made between new and existing contact lens wearers. This differentiation may affect the quantity of lenses supplied by the Plan and the professional fitting fee. Please refer to group specific Plan outline for further information.

A New Wearer is defined as a member meeting one of the following criteria: (1) a patient who has never worn/been fitted for contact lenses in the past; (2) a patient who is new to your office (whether a new wearer or an existing wearer); and (3) a patient who has previously been fit with contact lenses in your office, but is now being fit with a significantly different type of contact lens.

New wearers will receive a comprehensive lens fitting and lenses according to Plan protocol. The provider will receive a first time fitting fee including any co-payment, if applicable, which includes payment for the additional steps required to determine the optimal lens type that provides maximum comfort and visual acuity for the patient.

An Existing Wearer is defined as a patient previously fit with contact lenses in your office who is now being fit with the same or similar type of contact lens.

Existing wearers will receive a reassessment fitting and lenses, according to Plan protocol. The provider will receive a fitting fee including any co-payment, if applicable, for this service.

A two-tier formulary makes various types of contact lenses available including daily wear, disposable and planned replacement lenses. Information regarding co-payments will be provided in the group-specific Plan outline.

NOTE: This formulary is not always applicable to all groups. Please refer to the group-specific plan highlight sheet for complete contact lens information.

WARRANTY

FRAMES AND LENSES

Davis Vision will repair or replace (at our option) any lens or frame broken during normal use, providing that the eyeglasses are returned to your office within one (1) year of dispensing.

Davis Vision's laboratory assumes responsibility for redoing incorrectly fabricated eyeglasses, as well as eyeglasses to which patients cannot adapt.

SCRATCHED LENSES

Davis Vision's replacement warranty is extended to all lenses that have been treated with a scratch-resistant coating when applied either by the lens manufacturer or a Davis Vision laboratory and applies only to the original pair. Replacements are under warranty for the balance of the year. Please treat warranty returns as you would any other return.

CONTACT LENSES

Contact lenses are covered under the individual manufacturer's warranty. Please contact the appropriate vendor.

WARRANTY CERTIFICATE

A Warranty Certificate will accompany all Plan materials (eyeglasses and lenses) covered under Davis Vision's warranty (according to the rules described herein). Please deliver the warranty certificate to the member whenever dispensing Plan eyeglasses.

LABORATORIES

ORDERS

The Davis Vision CompuVision™ system is the state-of-the-art in order entry, allowing the provider to input information directly into our computer retrieval system with ease. Davis Vision's preferred order entry method is through the interactive provider web site at **www.davisvision.com**.

Providers have several options when placing an order with Davis Vision, including Fax Order Entry, Interactive Voice Response System (IVR) or via the Internet at **www.davisvision.com**. Please refer to the order entry section for complete information.

Davis Vision maintains its own regional laboratories for the Plan vision care benefit. These laboratories have earned a commendable reputation in servicing third party plans. Each provider is assigned to a regional laboratory, depending upon geographic location of the office.

LABORATORY SERVICES

In establishing order procedures, Davis Vision's goals were to assure:

1. Maximum convenience for providers.
2. Uniform format requirements of the order processing data system.
3. Accuracy and speed in processing orders.
4. Prompt reimbursement for services rendered.

PROVIDER-SUPPLIED FRAMES/PATIENTS' OWN FRAMES

Davis Vision's mail system was designed for ease. Ship Back Forms, Laboratory Order Forms (appended as Attachment "9") and Shipping Labels are provided.

Information to be included when mailing any frame to Davis Vision's laboratories:

- Member's name and identification number
- Invoice number that was generated when the order was placed
- Special instructions or explanation

When mailing a patient's own frame or a provider-supplied frame, please complete the Ship Back Form with the invoice number generated when the lens order was placed. This will facilitate matching your order with the patient's frame when it is received. Be certain to enclose one copy of the Ship Back Form with the Frame.

Davis Vision will supply doctors with Laboratory Order Forms and pre-paid, pre-printed shipping labels. Providers should send all returns to the assigned Davis Vision regional laboratory. The regional laboratory listing (with respective address and phone number) is contained in Section IX.

To avoid unnecessary delays, forms should be complete and legible. Ship Back Forms have tracking numbers, which allow Davis Vision to trace all returns. Please retain a copy of the label for your records.

SHIPPING ERRORS

In the event you receive eyewear for a patient that you did not service, please call Davis Vision at **1-800-888-4321** immediately.

Davis Vision will make arrangements with an appropriate carrier to pick up the package from your office the following day.

RECEIVING YOUR ORDER

All eyewear shipped from a Davis Vision laboratory to your office should meet the following criteria upon receipt:

1. Eyeglasses will have been cleaned, bench aligned, and polished to be ready for dispensing upon receipt.

2. Each patient's eyeglasses will be protected in an appropriate case.

3. A warranty certificate will be enclosed in each case, which is to be presented to the patient with the eyeglasses.

4. A copy of the original laboratory invoice will be included with the finished eyeglasses (wrapped around the case). We suggest you retain this copy. If jobs are returned for changes, it is important that you enclose a copy of this form.

DELIVERY

Davis Vision will make every effort to promptly fill all Plan supplied ophthalmic material orders. Single vision stock orders will be shipped within one (1) to three (3) business days and multifocals within one (1) to five (5) business days.

SECTION VII
CREDENTIALING

PREFERRED PROVIDER ORGANIZATION

A key component of the Davis Vision program is the Preferred Provider Organization (PPO). The network consists of select licensed optometrists and ophthalmologists in private practices that accept the quality improvement protocols and fee schedules established by Davis Vision. Recognizing that selectivity is the essence of quality, each Davis Vision practitioner undergoes an extensive screening before approval for participation in the network.

The following highlights the professional credentials that many of Davis Vision's existing preferred providers have achieved:

- Certification, American Board of Ophthalmology
- Faculty Members of Colleges of Medicine
- Faculty Members of Colleges of Optometry
- Fellows of the American Academy of Ophthalmology
- Fellows of the American Academy of Optometry
- Members of State Board of Examiners
- Officers of State/Regional Optometric Societies and Associations

To improve and maintain our performance and distinguish Davis Vision as the benchmark in the delivery of vision care services, we continually review and revise the requirements, qualifications and standards of care necessary to ensure the best quality possible. This involves listening to the suggestions of our network providers concerning possible additions or revisions to our established guidelines for credentialing. Davis Vision encourages an open dialogue with its network providers on all relevant subjects and can be reached via mail, phone or internet access.

INITIAL CREDENTIALING OF PROVIDERS

Credentialing is the initial process of evaluating potential providers by applying a set of established guidelines and standards. These guidelines, endorsed by the National Committee for Quality Assurance (NCQA) and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), were adopted by Davis Vision to identify the professional qualifications deemed necessary to provide quality patient care. Submission of a completed application does not constitute acceptance as a Davis Vision provider. Practitioners applying for a position on the Davis Vision panel may contact Davis Vision to request a copy of the Davis Vision Credentialing policy.

Davis Vision's extensive application and credentialing process assists itself in selecting the most qualified and experienced providers. It is worthy of note too that currently Davis Vision does not

delegate any of the credentialing activities discussed below to outside sources.

All practitioners must undergo primary source verification and validation of their professional background prior to rendering care to Davis Vision's members. Additionally, practitioners must submit documentation attesting that their offices meet the standards established by Davis Vision. All information submitted and verified will be no more than 180 days old at the time the Credentialing Committee reviews applications. In the event that the verification process exceeds the 180-day limit, a Supplemental Credentials Warranty (Attachment "10") will be signed by the practitioner attesting to the accuracy and completeness of the information that was provided on the original professional background form. Practitioners' verified credentials and the source of that verification are then presented to the Credentialing Committee for review.

All practitioner information received by Davis Vision will be considered confidential and will be maintained in a secure area and retained at the minimum for seven (7) years as a permanent part of the practitioner's file. Access to these files will be restricted to the departments and committees with a legitimate need to access this information under the support of the Vice President of Professional Affairs and those associates supporting the credentialing process must sign a confidentiality agreement. A provider may also be given access to his/her own file upon request. Certain documents such as reference letters will not be disclosed to providers. Davis Vision will make provider files available for audit purposes as required by law and for audits conducted by clients who have delegated the credentialing process to Davis Vision or accreditation agencies.

Disposal of confidential credentials information is critically important to Davis Vision too. Through a vendor agreement with Brinks, a national security company, numerous Brinks-designated document destruction boxes are stationed throughout the building for the disposal of confidential material. The boxes are routinely emptied by Brinks personnel and taken off premises in secured bags for shredding and disposal.

The distribution of provider offices reflects the client population being served and thereby meets the accessibility standards of Davis Vision. The standard formula Davis Vision subscribes to in expanding its networks is to assure that beneficiaries do not have to travel more than thirty minutes or twenty miles to receive services. Acceptance to the network is contingent upon the credentialing process and the determination of geographic need. Specific clients may contractually require a variation on the stated geographic standards. Utilizing a proprietary mapping program, quarterly reports are generated to assure that standards are met. Davis Vision makes the final determination of acceptability of all participating providers.

APPLICATION

Providers complete a detailed Vision Care Plan Provider Application (Attachment "2"), or uniform credentialing form as needed, and submit documentation detailing:

1. Professional Education and Training

2. State(s) licensure and Certification(s)

3. Board Certification (ophthalmology only)

4. Diagnostic Pharmaceutical Authorization (DPA) (optometry only)

5. Therapeutic Pharmaceutical Authorization (TPA) (optometry only)

   - To participate in certain plans, all optometrists must be TPA certified

6. Professional membership, Hospital Affiliation

7. Professional Work History for the past 5 years. Gaps in history require an explanation.

8. Professional malpractice insurance of $1 million per incident and $3 million in the aggregate. Amount must be equal to or exceed the community standards. The insurance certificate must be issued with the name of the provider.

9. A signed statement by the practitioner agreeing to comply with Davis Vision's policies on documentation, record maintenance, and patient confidentiality. All Applicants must sign a Participating Provider Agreement with Davis Vision.

10. Current and active Drug Enforcement Administration (DEA) certificate (if applicable)

    - Ophthalmologists must hold and maintain a current and active Drug Enforcement Administration (DEA) certificate, and, when applicable to the program, Optometrists would also be so required.

11. Copies of example patient care forms and records

Certain states may require that a specific uniform credentialing form be used as adopted through local regulation instead of the Davis Vision form. Davis Vision will accept these state-specific credentialing forms in lieu of its own application, if applicable, while still requesting further information/documentation not mentioned on those forms if necessary, and if allowable, by law.

PRACTITIONERS MUST INDICATE ANY HISTORY OF:

1. Professional malpractice actions, judgments/settlements. Claims resulting in settlements or judgments must be accompanied by details.

2. Any disciplinary proceedings pending against the practitioner by any licensing authority.

3. Any felony convictions or current indictment for any criminal offense in any state.

4. Any licenses being sanctioned, revoked, suspended or placed on probation in any state.

5. Suspension or expulsions by Medicare and/or Medicaid.

6. Termination or suspension from any panel or third party program or insurance.

ATTESTATION

Practitioners are required to sign a statement attesting:

1. That their mental or physical status would or would not affect their ability to practice their profession.

2. To the lack of impairment due to chemical and/or substance abuse.

3. That they have no history of loss, suspension or limitation of license and/or felony convictions.

4. That they have no history of loss, suspension or limitation of privileges or disciplinary activity.

5. That they will cooperate with scheduled on-site office visits including reviews of record documentation and, when requested, submit copies of medical and administrative records for audit purposes.

6. That they have completed six (6) hours of continuing clinical education (or satisfied their specific state's continuing education requirements, whichever is greater) relevant to their specialty within the previous twelve (12) months.

OFFICE STANDARDS

All applicants must provide documentation stating that their offices have:

1. Adequate hours of operation, minimally 12 hours per week

2. Appropriate examination room and equipment

3. Arrangements for Medical Specialty Care

4. Arrangements for Emergency Care, available 24 hours/day, 7 days/week

5. Full range of services available

6. Office Instrumentation that must include a Biomicroscope (Slit Lamp), Binocular Indirect Ophthalmoscope and Tonometer

7. Practitioners will agree to examine all Davis Vision patients without discrimination and provide them with the level of care and services provided to any private patient. Examination will require thirty (30) minutes.

CREDENTIALING PROCESS

Upon receipt of an application, the Recruiting Department reviews the application for completeness and assesses the qualifications of the candidates. During this initial review process all providers are registered and receive a temporary provider number pending final determination of their status. Practitioners will be informed of the status of their application upon request of the credentialing department.

Basic demographic information is collected. This includes name, social security number, tax I.D. number, Medicare and Medicaid provider numbers (including effective and expiration dates), state license numbers, office addresses, telephone, fax numbers and e-mail addresses.

The following Professional Background information is requested during the application process and, where indicated, verified during the credentialing process for all practitioners:

1. **Professional education and training**: Verification of all relevant education and training of an applicant is primary source verified. When an applicant Ophthalmologist is board certified, verification of certification is obtained through the American Board of Medical Specialties (ABMS). In addition, primary source verification of education through the Medical School is performed for all Ophthalmologists. Residency training and/or fellowship for ophthalmologists are primary source verified through the AMA Physician Master File and if the information is unattainable for whatever reason then the appropriate hospital or university will be contacted directly. Optometrists' education and degrees are primary source verified by contacting the appropriate schools and Colleges of Optometry directly. In addition, all providers must attest to meeting a six (6) hour minimum (or their state's minimum education requirements, whichever is greater) of continuing education each year.

2. **License**: Copies of current state licenses for the states in which the practitioner will provide care for Davis Vision members must be reviewed. Primary source verification is obtained by contacting the appropriate state agency (e.g., Department of Registration or Department of Education). Restrictions and history of loss of license in any state must be reviewed. When applicable to the program, valid Drug Enforcement Administration (DEA) certificate(s) (or equivalent) must be current. All active state licenses will be verified when reported. Licenses shall be primary source verified at its time of appointment, reappointment and time of expiration from the appropriate state licensing board. Applicants must submit a complete history of loss of license and/or felony conviction. Prospective providers must also provide a history of any loss or limitation of privileges or disciplinary activity. Information on all applicants from the State Board of Medical Examiners, the State Board of Optometry and the Department of Professional Regulations is requested. Previously reported sanctions by Medicare or Medicaid will be reviewed. Each month, the credentialing committee reviews the listing of all Medicare and Medicaid sanctions as detailed in the report issued by the Office of the Inspector General (OIG). When required by specific plan panels, adverse findings based on sanction reviews of practitioners who see plan members during the regular course of credentialing or monthly monitoring will be provided to them on a monthly basis.

3. **Professional Employment History**: Includes a description of work history (five-year minimum), and any gaps in work history must be explained. All practitioners are encouraged to submit Curriculum Vitae (CV). Work history will be verified if there is a gap of six (6) months or more (within the past five (5) years), or other questionable circumstances appear evident.

4. **Professional Membership and Affiliations**: Professional appointments including faculty appointments, state board of examiners, staff appointments and privileges at hospitals or institutional settings are requested. Clinical privileges for optometrists are desirable, however, Davis Vision shall not source verify these affiliations. Practitioners must indicate hospital affiliations and history of privilege suspensions, limitations, revocations or non-renewals. Loss or sanction of privileges will be a consideration of the credentialing committee at the time of credentialing/recredentialing.

5. **Malpractice History:** Candidates must detail any pending claims or any malpractice judgment or settlement made against them. Details of any settlements or judgments paid by or on behalf of the practitioner must be submitted. This includes the date of the incident, allegations and the status of the claim or resolution. When required by specific clients, documentation from the insurer must be provided. The presence of a malpractice history alone is not a reason for disqualification. The Committee considers whether there is any evidence of a pattern or the commission of a truly malfeasant act. All candidates must submit a current copy of their malpractice insurance policy declaration page indicating the name of the carrier, the policy number and the amount of coverage. All panel providers are required to maintain malpractice insurance at a minimum of $1 million per occurrence and $3 million in the aggregate, or the community standard.

6. **Physical and Mental Attestation:** The applicant attests to their physical and mental status and lack of impairment due to chemical dependence or substance abuse. Providers are obligated to notify Davis Vision immediately of any action, which may adversely affect continuation of any applicable licenses, of any suspensions or terminations by any other panel or third party programs, or of any malpractice actions.

7. **Signed Application and Participating Provider Agreement:** The vision care provider application (consisting of three sections: Practitioner Information, Office Information and Payee Information) and participating provider agreement is signed and dated by the primary applicant attesting to the completeness and accuracy of the information submitted. The "Practitioner Information" section must be completed, signed and submitted for each licensed professional providing services. Davis Vision requires one fully completed vision care provider application detailing the office(s) business information regardless of the number of practitioner associates in the office. Applications and supplemental warranties may not be dated more than 180 days from the date the Credentialing Committee reviews and approves an application.

8. **Application Review:** The Credentialing Department reviews the entire application for completeness including primary source verification of education, licensure and queries to the National Practitioner Data Bank, Healthcare Integrity and Protection Data Base, the Office of the Inspector General, State Licensing Boards and other appropriate databases when

indicated. The staff verifies facility privileges and DEA registration, where applicable. During the verification process, whenever credentialing information obtained from primary or secondary sources varies substantially from submitted information practitioners will be contacted in writing and extended an opportunity to correct erroneous information, with an explanation and supportive documentation, prior to review by the Credentialing Committee. This includes any adverse licensure actions for the applicant, malpractice claims history, etc. Such notification will be communicated to the practitioner within thirty (30) days of discovery. Practitioners then have ten (10) business days to provide corrected information to the appropriate credentialing associate. A credentialing checklist is completed (Attachment "11"). Questionable items are flagged for further review. All information will be no more than 180 days old at the time of Committee review.

In addition, the Credentialing Department reviews Medicare Opt-Out Reports supplied by Part B carriers in order to determine if a practitioner has exercised their option to decline remuneration from Medicare or Medicaid programs. As such, if a practitioner has opted for prohibition from receiving federal funds, which is valid for a period of at least two (2) years, the Credentialing Department will make sure that upon approval by the Credentialing Committee for inclusion within the provider network that they are not placed on any of Davis Vision's Medicare or Medicaid network panels.

The Opt-Out Reports will be reviewed on a quarterly basis as well to ensure that any practitioners who have "opted out" subsequent to initial credentialing will be removed from any Medicare or Medicaid panels they may have been initially assigned to.

9. **Credentialing Committee Review:** All completed files are then signed by the credentialing department associate in attestation to the completion of the primary verification as applicable and forwarded to the Credentialing Committee (comprised of licensed practitioners and including at least one (1) active practitioner in the network) for review and final determination. The average time required for completion of the credentialing process per provider is thirty (30) days, but shall not exceed ninety (90) days.

   The Credentialing Committee may take one of three actions after review of the applicant's file: (1) approve the applicant for panel membership (2) request more information or (3) deny participation based upon the report and evidence submitted by the Credentialing Department associates. Assuming the office is deemed acceptable, the practitioner is notified by a Professional Affairs Department representative via mail within sixty (60) days of the decision. Upon notification of acceptance, the Professional Field Consultant Department will arrange an orientation for the provider and their office staff, at which time all necessary plan materials, including the Provider Manual and required forms, would be supplied to the practitioner's office.

The completed Credentialing Checklist will be included in the provider's file and shall specify the programs the provider may participate in and whether there are any applicable restrictions or limitations.

Upon final approval of the Credentialing Committee's recommendation for a practitioner's acceptance into the network, an authorized Recruiting Department associate will enter the provider's data into CompuVision™ and the appropriate participating provider listings.

In the event that the Credentialing Committee requires additional information, Davis Vision will notify the applicant to submit the necessary information to the attention of the credentialing department. If the applicant does not comply within ten (10) business days, the Committee will consider the application voluntarily withdrawn.

In the event the Credentialing Committee recommendation to deny membership is upheld by Davis Vision's leaders, detailed information shall be indicated in the minutes. Practitioner(s) shall also be notified of the decision by mail within sixty (60) days of said decision, and given the opportunity to correct any erroneous information and the right to appeal the decision based upon erroneous information. Davis Vision, upon request of the provider, will make available documentation, excluding NPDB/HIPDB Query, references or recommendations, or confidential information obtained during the credentialing process.

To ensure timely, complete and accurate records, an appointed committee member will record minutes for all Committee meetings in an approved standardized format. The minutes are to reflect recommendations, actions and participation by Committee members and must be approved by two (2) members of the Committee. Committee recommendations are approved, finalized, signed and dated by the Vice President of Professional Affairs and Quality Management or the Director of Professional Services. Minutes are kept in a secured file in the Credentialing/Quality Improvement office and shall be retained for a period of at least seven (7) years.

Following the approval of the Credentialing Committee and the issuance of a provider number, new practitioners receive manuals and are oriented to Davis Vision's policies, procedures, plans and billing procedures. Additionally, providers may receive shipment of Davis Vision frames.

Candidates may not be refused appointment for reasons of age, sex, religious beliefs or any other elements considered under the Equal Employment Opportunity Act and the Americans with Disabilities Act. This Act is outlined within the Highmark Code of Business Conduct. In fact, each member of the credentialing committee is required to sign a conflict of interest statement so as to avoid discriminatory practices while assessing potential candidates for Davis Vision's network and the application does not request any information concerning age, gender, religious affiliation or the like either, therefore such data is not and cannot be used by Davis Vision to engage in any discriminatory practices.

RECREDENTIALING PROCESS

Recredentialing is a process that Davis Vision conducts a minimum of every three (3) years from the date of initial credentialing. As part of the Recredentialing process, providers are required to submit updated copies of previously submitted documentation, such as practitioner's license(s), malpractice insurance and employment history. Recredentialing of providers can include the

review of Quality Improvement indicators, utilization management, record review, site visitations, member complaints and member satisfaction surveys.

Davis Vision's recredentialing process is ongoing and consistent with regulatory agency requirements. Providers are obligated to notify Davis Vision immediately of any action, which may adversely affect continuation of any applicable licenses, of any suspensions or terminations by any other panel or third party programs, or of any malpractice actions. Independent of this requirement, Davis Vision confirms and source verifies credentials.

The credentialing-based component of Davis Vision's CompuVision™ system monitors documentation and compliance with recredentialing requirements. Credentials of all providers must be reviewed a minimum of every three (3) years. Providers whose licenses expire prior to recredentialing shall be contacted and current licenses will be verified.

1. At the time of recredentialing, all documentation in the provider files must be updated and current. This includes copies of current license(s), certificates and malpractice insurance policies. Verification of active state licenses as applicable to the location where the practitioner will provide services to Davis Vision members shall be obtained through contact with the appropriate agencies (e.g., Department of Registration and Department of Education). Verification of board certification for ophthalmologists is obtained through the American Board of Medical Specialties and is performed as a matter of course in order to determine if the provider has acquired an additional board certification, or the original certification has expired, since the last credentialing. A current copy of the malpractice insurance policy declaration page including the amount and dates of coverage must be supplied. Written and updated reports from the National Practitioner Data Bank and other appropriate databases are obtained on all active participating providers. All information should be no more than 180 days old at the time of Committee review. All recredentialed providers shall be reviewed for any Medicare/Medicaid sanctions.

2. Recredentialing also includes completion of a Supplemental Credentials Warranty form with an original signature for all licensed persons providing services. This includes the provider's acknowledgement and understanding of Davis Vision's policies and procedures and a statement attesting to their physical and mental status and lack of impairment due to any chemical dependency or substance abuse. The Supplemental Warranty attests that information provided in the original "Practitioner Information" section of the vision care provider application remains current and accurate and that the provider has completed at least six (6) hours of continuing education per year (or satisfied their state's continuing education yearly requirements) since the date of their original application.

3. Patient satisfaction surveys are reviewed and summarized semiannually. These surveys include data on patients' perception of the quality of the examination and the treatment received during an office visit. Summation data includes the number of patients examined by the provider and the number of survey responses. All comments from the satisfaction surveys are reviewed as received. Any complaints or adverse comments are referred to the Vice President of Professional Affairs and Quality Management for review and disposition. Positive reports regarding exceptional service are noted.

4. Member compliment, complaint, and/or grievance reports/logs maintained by the Quality Assurance/Patient Advocate Department are reviewed on an ongoing basis. In response to these reviews a specific report is generated each quarter by the Quality Assurance Department regarding individual providers including the number and disposition of said complaints which, in turn, is kept in each provider's file. Incidents that warranted an investigation will have a copy of that report in the provider's file for review as well.

5. Utilization data on all providers is reviewed semiannually. A provider monitoring system that incorporates a provider profile of services and submitted charges is maintained. This claims management system generates retrospective data and patterns of use among providers. Individual provider data and comparative data on all providers enables us to assess patterns of usage and identify those providers that deviate from the norm.

6. "High volume" providers with more than 300 services rendered to Davis Vision members annually will be subject to an office visitation once every two (2) years by a Regional Quality Assurance Representative (RQAR). This includes an office and record review. A scoring mechanism will be utilized and an overall assessment is made. Office visitations of high volume practitioners can only commence once a provider is on the panel for an appropriate length of time. Providers with more than 100 patient visits but fewer than 300 annually may be required to submit copies of records every two (2) years for review by members of the Professional Peer Review Committee. The Credentialing Committee reviews the results of these audits during the recredentialing process.

7. Results of provider site visitations (those meeting the high volume threshold) and record audits are reviewed. Providers who fail to meet the standards established by Davis Vision for the site visit are subject to reduction, suspension or termination from membership on the panel. Results of site visits will be considered at the subsequent recredentialing cycle. Site review criteria include physical environment, safety, infection control, medical record review and documentation. A copy of the site visit and record review form is appended as Attachment "12". The Regional Quality Assurance Representatives and the Director of Professional Services review questions relating to the quality of care rendered.

8. A Recredentialing Checklist specifies the Credentialing Committee recommendations for approval or denial. Final decisions are the responsibility of the Vice President of Professional Affairs and Quality Management.

9. Providers will be sent a letter, via mail, regarding their re-credentialing status within sixty (60) days of the final decision of the Credentialing Committee.

CONTINUOUS MONITORING OF SANCTIONS AND COMPLAINTS

Davis Vision maintains an on-going and continuous monitoring system of sanctions and complaints unrelated to the recredentialing process. Lists and communications from agencies such as the State Licensing Board and the Office of the Inspector General are reviewed monthly to ensure that Davis Vision participants are not among the providers cited. Complaints received by telephone or as a result of patient surveys, are immediately reviewed. After receiving services, patients are sent satisfaction forms to assess their perceptions and opinions regarding the care. All patient satisfaction surveys include the statement "If you would like a Davis Vision Representative to contact you, please check this box." Complaints dealing with quality care issues are forwarded to the Vice President of Professional Affairs and Quality Management. When appropriate, additional site visitations and/or medical record audits unrelated to the recredentialing process may be scheduled. Record reviews are also part of our on-going quality program to ensure continuous assurances. Monitoring of sanctions as agencies make them available, but always within thirty (30) days, and complaints is an unending process that begins when a provider is initially credentialed and is continuous between recredentialing cycles.

All providers are required to notify Davis Vision within thirty (30) days of any licensure sanctions (including probations or limitations, suspensions or terminations) by any other panel or third party program, all malpractice actions and any sanctions or changes in participation within the Medicare and Medicaid programs. Between recredentialing cycles, Davis Vision reviews the report from the Office of the Inspector General to ensure that Medicare and Medicaid have not sanctioned providers.

TERMINATION AND SUSPENSION

Davis Vision's Practitioner Termination and Appeals policy is designed to define the criteria by which Davis Vision evaluates practitioners for possible termination or other actions as warranted. Davis Vision will provide a copy of the appeals process whenever a notice of action is sent to a provider.

Davis Vision contracts with practitioners so that it can offer quality, accessible cost-efficient vision care to its members. Davis Vision monitors and evaluates the care provided by its network practitioners to ensure that such vision care is being rendered. Davis Vision utilizes these reviews during the recredentialing and/or termination process.

Davis Vision or a participating provider may terminate the provider agreement without cause after the first twelve (12) months with prior written notice. If the provider terminates the agreement without cause, or should a particular practitioner leave provider's practice or otherwise become unavailable to the participants, they are to notify said participants of this action prior to the effective date of the termination for the purpose of determining further action regarding any continuous courses of treatment.

If the agreement is terminated or suspended without cause prior to the agreement's termination date, Davis Vision shall give the provider at least ninety (90) days prior written notice; and, in the event of such a termination or suspension, the provider has a right to request a hearing following such notice except that no notice or hearing will be given when termination is based on non-renewal of the agreement, a determination of fraud, breach of contract by the provider, or the opinion of Davis Vision that the provider represents an imminent danger to a patient or the public health, safety and welfare of participants. Davis Vision may terminate the provider agreement immediately for cause or may suspend continued participation as set forth below.

"Cause" shall mean:

CAUSE FOR TERMINATION

1. A suspension, revocation or conditioning of provider's license to operate or practice his/her profession.

2. Suspension or a history of suspension from Medicare or Medicaid or any other third party plan.

3. Conduct by provider that endangers the health, safety, or welfare of participants.

4. Any other material breach of any obligations of provider under the terms of the Provider Agreement.

5. Conviction of a felony.

6. Loss or suspension of a Drug Enforcement Administration (DEA) identification number.

7. Voluntary surrender of the provider's license to practice in any state in which the practitioner serves as a Davis Vision provider while an investigation into the provider's competency to practice is conducted by that state's licensing authority.

CAUSE FOR SUSPENSION

1. A failure of provider to maintain malpractice insurance coverage as previously stated.

2. A failure by provider to comply with applicable laws, rules, regulations, and ethical standards.

3. A failure by provider to comply with Davis Vision rules and regulations as outlined within this manual.

4. A failure by provider to comply with Davis Vision's, and any Plan's, utilization review and quality management procedures as applicable.

5. A violation by provider of the non-solicitation covenant set forth within the participating provider agreement whereby provider agrees not to directly or indirectly engage in the practice of solicitation of participants, plans or any employer of said participants without Davis Vision's prior written consent.

When a provider is terminated based on professional misconduct or their conduct poses a threat of imminent harm to the health and safety of a member, or when their license limits their ability to fulfill their contractual obligations to Davis Vision, the provider forfeits the right to appeal the decision.

Davis Vision retains the right to limit or terminate panel providers based on non-quality issues, which may include, but are not limited to:

- Lack of Board Certification and DPA licensure;
- Excessive number of panel providers practicing in a geographic area;
- Failure to comply with the recredentialing process;
- Failure to comply with on-site and/or record reviews.

The Credentialing Committee will review the termination of any provider appropriately. In performing the review, the Committee will consider all available material concerning the panel provider. The Committee may, at its own discretion, request that the practitioner submit written explanation of the issues under review or that the practitioner submit written responses to questions posed by the Committee. The outcomes of all reviews are forwarded to the Director of Professional Services.

Possible actions that the Director of Professional Services may take include, but are not limited to: sending an educational letter or continuing observation with the recommendation that the practitioner's participation in the network be restricted, suspended or terminated.

When the Committee recommends that a panel provider be suspended or terminated, it will issue and forward the recommendation to the Director of Professional Services. The Director of Professional Services will then issue a written notice of the proposed action to the practitioner by certified mail (with return receipt requested). The notice of the proposed action will indicate the recommended action, the reason for the decision and the manner in which the practitioner may appeal the decision.

A decision to terminate a provider by the Director of Professional Services becomes effective immediately upon receipt of notice by the practitioner. The practitioner then has thirty (30) days to appeal the decision.

PROVIDER RIGHTS

A practitioner's participation will not be terminated due to any of the following reasons:

- Advocating on behalf of a member

- Filing a complaint against Davis Vision
- Appealing a decision of Davis Vision
- Requesting a hearing or review

APPEALS PROCEDURE

To challenge a termination decision, a practitioner must notify Davis Vision in writing of their intention to seek modification or reversal. The practitioner must send a written request for a hearing to modify or reverse a decision to terminate to the address listed on the notice of action. The request must be sent by certified mail, return receipt requested and postmarked no later than thirty (30) days following receipt of the notice of action by the practitioner.

Within thirty (30) days of receipt of a request for a hearing to modify or reverse the decision to terminate, a three-member Appeals Committee composed of at least one Regional Quality Assurance Representative, who is also an active practitioner within our provider network, not involved in the initial determination shall convene to review the merits and circumstances presented. Notice of the hearing will be sent at least ten (10) days before the scheduled hearing date and will advise of the provider's right to be represented by an attorney or other person of their choice if they wish to be. Failure to appear at the hearing will be deemed a waiver of the practitioner's right to appeal.

If the practitioner requires additional time or wishes to reschedule the hearing, the request for additional time or to reschedule must be made in writing, sent by certified mail (return receipt requested), and be received at Davis Vision at least ten (10) days before the scheduled hearing before the Appeal Committee.

Any documentation to be submitted by the practitioner at the hearing before the Appeals Committee, including the names, addresses and credentials of any witnesses, if applicable, must be mailed to the address listed in the notice of action by certified mail, return receipt requested and be received at least ten (10) days before the scheduled hearing date. The Appeals Committee at its discretion may accept documentation or testimony of witnesses received after this date.

At the hearing, the practitioner will present his/her explanation as to why the decision for termination should be modified or reversed. The Director of Professional Services will present Davis Vision's position regarding the termination.

The Appeals Committee will prepare a report containing its findings and recommendation with respect to the appeal and forward the report to the Vice President of Professional Affairs and Quality Management, within thirty (30) days of the hearing who, in turn, considers the Appeals Committee's findings and recommendations and either accepts or rejects them within fifteen (15) days. If the findings and recommendations are accepted, the Vice President of Professional Affairs and Quality Management will advise the practitioner in writing of the decision to accept the Appeals Committee's report as submitted, a copy of which will be enclosed. If the Vice President of Professional Affairs and Quality Management rejects any of the Appeals

Committee's findings or its recommendations, he will issue a decision stating the reasons for rejecting the particular finding or the recommendation, a copy of which will be sent to the practitioner. Where the decision of the Vice President of Professional Affairs and Quality Management results in the termination of a practitioner, Davis Vision will notify the practitioner in writing of his or her effective termination date. The termination date is effective upon the practitioner's receipt of the notice. The decision of the Vice President of Professional Affairs and Quality Management constitutes Davis Vision's final decision with respect to the practitioner's network participation status.

If the decision of the Vice President of Professional Affairs and Quality Management results in the termination of a practitioner's participation in accordance with the above policy, Davis Vision will notify, when appropriate, the National Practitioner Data Bank (NPDB), the Healthcare Integrity and Protection Data Bank (HIPDB), and the appropriate state licensing board(s) of its actions.

In order to report to NPDB-HIPDB a provider's termination from the network the termination must be related to professional competence or conduct, adversely affecting clinical privileges for a period longer than thirty (30) days, or the provider's voluntary surrender or restriction of clinical privileges while under, or to avoid, investigation. This report will be submitted within fifteen (15) days of the termination.

Reports will be submitted via the IQRS application available through the NPDB website: www.npdb-hipdb.com. IQRS includes a draft report feature allowing for report data input and saving. In addition, a copy of the report must be mailed to the appropriate state licensing board.

REASONS FOR PROVIDER RECRUITMENT

The Davis Vision provider panel is under continuous review. New providers are continuously being added in areas of identified need. Need may be based on demographic, geographic or quality criteria. Every eye care professional expressing interest in participation is afforded the opportunity to complete and submit an application and be given fair consideration for participation. The panel has grown historically in conjunction with client group needs and will be expanded as needed to ensure convenient access for every beneficiary.

The primary reasons why Davis Vision solicits applications from vision care practitioners are:

- To provide conveniently located access to care for eligible members.
- Davis Vision has identified a need for additional providers in specific geographic regions as determined by internal survey or in response to a patient needs assessment.
- Groups recommend providers.
- Patients recommend providers.
- Providers request network participation.

Davis Vision restricts its panel size to assure adequate network coverage and quality. Only qualified and experienced practitioners in each geographic area are accepted for participation. This determination is based upon each provider's credentials and practice history, thereby assuring the provision of high quality care. Davis Vision does not charge providers any membership or administrative fees, nor is any portion of scheduled payment withheld. Quality of care and geographic need are the sole considerations.

DETERMINATION OF GEOGRAPHIC NEED

The need for provider recruitment stems primarily from an expansion of clients/members in specific geographic areas that are currently not adequately represented or under represented by existing Davis Vision providers. Additional reasons may include providers who fail to qualify or maintain a position on the panel or the retirement of existing providers. The need to maintain an adequate patient-provider ratio is always a consideration.

Provider recruitment based on these needs may necessitate a National Provider Recruitment Drive or Targeted Recruitment. This approach may involve sizeable mailings of provider application materials and accompanying recruitment material. The list of providers for such mailings may be drawn from, but not limited to, the following sources:

- Professional Directories
- National Yellow Pages CD-ROM by running a search on occupation
- Databases maintained by Davis Vision
- Client or member recommendations

If provider recruitment has to be expedited for any reason (particularly for the purpose of preventing an interruption of patient care), a provider recruitment representative may telephone a practitioner directly and encourage the practitioner to submit an application. The Provider Recruitment representative would typically:

- Describe Davis Vision's role as an administrator of vision care plans. Specify the Davis Vision client groups that the provider would serve.
- Explain how the Davis Vision Plan is administered and provide details on fees and reimbursement schedules.
- Encourage the potential provider to return a completed application after it is determined that they posses the appropriate experience and qualifications. The credentialing process will also be explained.
- Conclude the conversation by expressing that participation in the Davis Vision network will provide a mutually satisfying relationship.

The first step in developing and/or maintaining a provider network for current or future Davis Vision members is achieved by creating a GeoAccess™ report. Data generated by GeoAccess™ is analyzed to determine the ratio of providers and members in a given geographic location. Based on the GeoAccess™ analysis and other considerations such as budget, client contract or Davis Vision's ability to guarantee quality care to members, a recruiting drive is initiated.

The standard formula Davis Vision subscribes to in expanding networks is to assure that beneficiaries do not have to travel more than thirty minutes or twenty miles to have access to qualified providers to receive services. The ratio of providers to members averages 1:1500 (our providers to insured ratio). This ratio, in a travel time model encompassing urban vs. rural demographics, is structured to ensure ease of access for all members. This formula enables the quality/cost assurance functions to be effective through a manageable and controlled network.

PRACTITIONERS REQUESTING NETWORK PARTICIPATION

All practitioners have an opportunity to contact Davis Vision directly to seek information regarding the company, its vision plans or information on becoming a panel member.

A Recruiting Department associate, while expressing pleasure in the practitioner's interest in becoming a network provider, will indicate whether Davis Vision network has a "vacancy" in their geographic area. Although the decision as to whether a practitioner may be included within the Davis Vision provider network would never be based upon race, ethnicity, gender, age or sexual orientation it may be made based solely upon the fact that their particular practice area simply does not have a vacancy need for another practitioner in such close proximity.

However, all practitioners regardless of "vacancy status" are encouraged to complete and return the provider application. The completed application is kept on file until a vacancy occurs. Practitioners are informed that a credentialing department associate will contact them when a vacancy occurs so any information that has been on file longer than 180 days can be updated. This database will permit Davis Vision the opportunity to contact this practitioner when a vacancy occurs. This process allows Davis Vision to continually meet the needs of its members without any interruption in services.

GROUPS RECOMMEND PROVIDERS

Davis Vision's commitment to "100% Internal and External Customer Delight" includes those members currently under the care of non-network practitioners. Davis Vision will work closely with groups to include, wherever possible, non-network doctors who are currently providing vision care services to Davis Vision beneficiaries. This relationship will help ensure continuity of care and member satisfaction. Davis Vision sees the relationship with the client as a partnership striving to ensure quality care for all members.

Recommended non-network doctors are encouraged to become a Davis Vision panel provider if the need exists. (Refer to **Determination of Geographic Need**.) This association would create a relationship that is mutually beneficial to all concerned. Members would benefit by knowing that a committee of peers approved their provider and that the care they are receiving meets standards established by various accreditation agencies and is audited by Davis Vision to ensure compliance with these standards. As a panel provider, the recommended group non-network practitioner will have the opportunity to render services to all Davis Vision members in their

service area and Davis Vision will have the assurance that all members will receive the quality of care standards that Davis Vision has established.

All group-recommended non-network doctors will be notified and will receive the Provider Application by mail. Completed provider applications and submitted documentation will be source verified and submitted to the Credentialing Committee for approval. These applications will be reviewed based upon the credentialing standards and access considerations.
All recruitment policies and procedures are designed to afford all applicants fair process in compliance with the Health Care Quality Improvement Act of 1986.

SECTION VIII
DOCTOR-PATIENT RELATIONS

APPOINTMENT

Davis Vision's members will contact your office directly to schedule an appointment.

The patient will have selected your name from the Participating Provider Directory. The directory is also available on the Internet at **www.davisvision.com** for eligible members. The requirement to make an appointment is emphasized in the listing.

When making the appointment, your office personnel should obtain the member's name and member identification number, patient's name (if differs) and date of birth and their relationship to the member. Patients should be reminded to bring identification at the time of the examination.

It might be useful to remind patients to notify your office if they are unable to keep their appointments. If appointments are made in advance, confirmation phone calls can serve as helpful reminders. Appointments should be honored within a reasonable time period.

It is Davis Vision's policy that providers are responsible for verifying patient eligibility. Providers can log on to the Davis Vision web site at **www.davisvision.com** or call the Interactive Voice Response at **1-800-77DAVIS** to verify eligibility and receive authorization. Providers are not obligated to provide non-emergent services for members who fail to produce proper identification or members who are not eligible for services.

There should be no discrimination in making appointments. Plan participants should have the same hours available to them as private patients.

PATIENT RIGHTS, RESPONSIBILITIES AND ETHICS

It is the policy of Davis Vision to adhere to the Patient's Bill of Rights and involve members and/or appropriate family members or an authorized representative of the member in all aspects of treatment, care and services. All Davis Vision members have the right to file a grievance without fear of reprisal.

Davis Vision informs members of their Patient Rights by posting the Patient's Bill of Rights on the Davis Vision Web Site. The Patient's Bill of Rights is also included in the Provider Manual, and providers are encouraged to communicate these rights to their patients. Additionally, all patients have the right to call Davis Vision member services department and request a copy of the Bill of Rights.

Members have the right to considerate care that safeguards their personal dignity and respects their personal values. Patients have the right to be aware of all their financial responsibilities prior to receiving any treatment and services. Members may call Davis Vision or log on to the Davis Vision web site at **www.davisvision.com** to obtain this information.

Davis Vision integrates a Code of Professional Ethics, Standards of Care and Quality Improvement Program to ensure that all Davis Vision Associates and providers comply with our ethical and legal responsibilities and requirements. The Code is intended to reinforce the principle that we all have a responsibility to ensure that the company operates ethically in its business conduct and that no one is forced to act or to work with others who act in an unethical manner.

All Davis Vision associates and all participating providers are instructed to assist any patient with a complaint or grievance relating to the care received or the benefit program.

PATIENT BILL OF RIGHTS

Courtesy, dignity, confidentiality, communication and privacy are essential to services provided by Davis Vision. Davis Vision strives to ensure that all providers regard and uphold these rights:

1. *Patients have the right* to understand and use these rights. If for any reason patients do not understand the rights or require assistance, Davis Vision's staff will provide assistance. Patients, including the hearing and speech impaired, have the right to receive communications in a language and manner that is understood by the member.

2. *Patients have the right* to receive treatment without discrimination as to race, color, religion, sex, age, national origin, disability, sexual orientation or source of payment.

3. *Patients have the right* to receive materials that clearly explain the scope of covered benefits, such as information regarding accessing covered benefits, including requirements for prior authorization and accessing emergency or out-of-area services; cost-sharing features under the benefits plan and coverage exclusions. Patients are provided with a mechanism to access a directory of participating providers.

4. *Patients have the right* to expect continuity of care and to know in advance what appointment times and services are available in which locations.

5. *Patients have the right* to choose all plan services and options. When full service benefits are chosen, the provider agrees to accept the plan fees as payment in full. Where co-payments are applicable, patients have the right to an explanation of all such charges. Patients have the right to choose non-plan materials with the understanding that they are responsible for all applicable charges.

6. *Patients have the right* to be shown the Davis Vision Plan Collection and choose a frame from the Tower Collection (where applicable).

7. *Patients (and their families when appropriate) have the right* to know all options, therapies, treatments and services available to them regardless of any restrictions imposed by the vision care plan. Practitioners should not be deterred or constrained from presenting these options to the patient. The right entitles the patient access to information on services whose scope or frequency may exceed that which is allowed under the plan. Patients shall be informed of all professional fees prior to the provision of such services.

8. *Patients have the right* to receive considerate and respectful care in a clean and safe environment.

9. *Patients have the right* to know the name, position, and function of any office staff involved in care, and may refuse their treatment, examination or observation.

10. *Patients have the right* to know the names, qualifications and licenses of all providers involved with their care. If an optometrist is involved, they have the right to know whether the provider is certified to use diagnostic pharmaceutical agents and/or therapeutic pharmaceutical agents. If an ophthalmologist is providing care, they have the right to know if they are board certified.

11. *Patients have the right* to receive complete information about their diagnosis, treatment and prognosis. *Patients have the right* to receive all the information needed to give informed consent for proposed procedure or treatment. This information shall include the possible risks and benefits of the procedure or treatment. Patients are expected to provide all necessary information to providers to facilitate effective treatment. Patients are responsible for providing, to the best of their knowledge, accurate and complete information about their complaints, medical and family history, eye and vision history and any other pertinent information.

12. *Patients have the right* to refuse treatment and be told what effect this may have on their health.

13. *Patients have the right* to privacy while in the office and confidentiality of information and records regarding their care. Patients have the right that safeguards be adopted to protect their privacy and the confidentiality of all patient data gathered by Davis Vision participating providers. The release of protected information will be provided only to authorized agents and appropriate regulatory authorities.

14. *Patients have the right* to review, comment upon and request correction of health information on their medical record and obtain a copy of the medical record, for which the office may charge a reasonable fee. Patients cannot be denied a copy solely because they cannot afford to pay. The right allows patients to review, comment upon and request correction of health information on their medical record

15. *Patients have the right* to receive the Davis Vision Privacy Practices Notice describing how their medical information may be used and disclosed and how they may gain access

to this information as dictated by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

16. *Patients have the right* to receive, without charge, a copy of their eyeglass prescription. Patients wearing contact lenses have the right to receive a copy of their contact lens prescription only after the lens fit has been confirmed as stated in the *Fairness to Contact Lens Consumers Act*. The prescription may contain an expiration date.

17. *Patients have the right* to receive an itemized bill and an explanation of all direct charges.

18. *Patients have the right* to be satisfied with the care and treatment provided. Patients have the right to voice their grievances, objections and dissatisfaction regarding the care and/or the cost of treatment of care received without the fear of reprisal. Patients have the right to appeal decisions initially unfavorable to their position. Patients have the right to a system that provides for the receipt and resolution of complaints and grievances in a timely manner.

19. *Patients have the right* to refuse to take part in any research or investigational studies.

PATIENT RESPONSIBILITIES

All members are expected to provide information requested by practitioners providing their care. Members will be informed of their responsibilities as described under Patients Rights Policy.

Davis Vision members are responsible for providing, to the best of their knowledge, accurate and complete information regarding the following:

- Present complaints.
- Medical History and any other significant events, including surgical history.
- Eye and vision history, social and family history.
- Current medications.
- Allergies and reactions.
- Any other pertinent information.

Additionally:

- Members are responsible for reporting when they lack a clear understanding of a proposed course of action and what may be expected of them.
- Members are responsible for following treatment recommendations, including using prescribed medications or treatments and reporting any factors that may prevent them from doing so.
- Members are responsible for respecting the rights of others, including, but not limited to, other patients, staff and providers.

- Members are responsible for assuring that the financial obligations associated with their care, including co-payments and fees for non-covered services, are met in a timely manner.
- Members are responsible for notifying providers at the time an appointment is made that they are covered by a Davis Vision Plan.
- Members are responsible for notifying providers at least 24 hours in advance when canceling any appointment.
- Members are responsible to use the benefit in an honest manner.
- Member should be aware that providers who care for them are not employees of Davis Vision and that Davis Vision does not control them.
- Members are permitted to question providers about all treatment options and provider's compensation arrangement with Davis Vision.
- Members are responsible to ensure that their provider has received the proper authorization for services.
- Members are responsible to report any concerns to Davis Vision at 1-800-584-1487.

PATIENT CONFIDENTIALITY

Davis Vision has established and maintains a HIPAA Privacy Office, under the direction of the Company's designated Chief Privacy Officer for Davis Vision strategic business units, including vision care and proprietary vision centers. The Privacy Office develops, obtains approval for, implements and monitors compliance with the necessary procedures and protocols that are required to assure full compliance with HIPAA Privacy Regulations.

The Privacy Office also audits compliance, investigates allegations or reports of privacy breaches and coordinates responses as appropriate and serves as liaison with other privacy offices.

The Privacy Office prepares monthly reports for the Senior Executive Management team on the activities of the Privacy Office and the Chief Privacy Officer meets with the Senior Executive Management team at least quarterly to review compliance. Any breach of privacy, along with proposed mitigation actions, are required to be reported to the Senior Executive Management team within 24 hours of the Privacy Office being notified. The Davis Vision Privacy Practices Notice describes how a patient's medical information may be used and disclosed as well as how they may gain access to this information as dictated by HIPAA (Attachment "13").

Davis Vision has a moral, legal and professional obligation to protect the confidentiality of the patient's care record, protected health information and personal information. Davis Vision's members are entitled to confidential, fair and respectful treatment of health information about themselves or family members. Davis Vision will abide by all applicable state and federal laws protecting patient confidentiality and the confidentiality of individual medical records. Davis Vision will not release any patient information without proper authorization from the patient and/or as required by law or judicial decree. It is our policy to ensure the confidentiality of any health information submitted to or by Davis Vision that would identify the member or patient. All member/patient specific information will be considered confidential and is therefore protected. Member benefit and/or eligibility status, while confidential, is not considered protected.

Protected Health Information means any information or data that is created by or received by Davis Vision that would identify an individual and contains information regarding the past, present or future health status of that individual.

Eligibility information refers to information (written or verbally or electronically communicated) which indicates a member's eligibility for past, present or future services, as provided under the member's benefit plan. Eligibility information does not include protected health information.

DISCLOSURE OF INFORMATION

Davis Vision shall not disclose any health information about a member received by or collected by Davis Vision unless disclosure is:

- Requested by the member, legal guardian or legal representative. Proper identification is required prior to release of information. Written authorization must be dated and signed within the past thirty (30) days.
- For the purpose of an audit of Davis Vision's claim processing operations. Released information must be relevant to conducting the audit. Any outside agency reviewing information must agree to abide by Davis Vision's confidentiality policies.
- Reasonably necessary for Davis Vision to conduct an audit of utilization by provider.
- To an authorized regulatory or accrediting agency conducting a survey and/or audit. The agency must agree to abide by Davis Vision's confidentiality policies.
- To a governmental authority or law enforcement agency while investigating or prosecuting the perpetration of fraud upon Davis Vision or a Davis Vision client.
- Reasonably necessary for the investigation of suspected fraud or abuse by a member or provider.
- To Davis Vision Committees, such as the Credentialing, Utilization Review and Quality Improvement Committees, which are responsible for conducting peer review audits.
- In response to a court order.
- In response to a governmental authority for the intent purpose of verifying a member's eligibility for which the government is responsible.
- When otherwise authorized or required by federal, state or local laws.

Davis Vision will disclose eligibility information when:

- A member, member's legal spouse, member's dependent child(ren) or participating provider produces proper identification or eligibility documentation.
- A member or any listed plan beneficiary accesses the Interactive Voice Response system, speaks with a Member Service Representative or logs on to the Davis Vision web site and provide the appropriate member identification number.

Davis Vision's confidentiality policy is incorporated into the orientation process for all new associates of Davis Vision. Davis Vision as a wholly owned subsidiary of Highmark, Inc. has adopted Highmark's Integrity Process. The Integrity Process holds all associates responsible to adhere to the principles and practices stated in the guidebook.

Davis Vision considers all information that is patient-specific to be confidential. Such information will always be:

- Considered confidential and will be stored in a secure file.
- Shared only with those associates who have a legitimate need to view such information, including, but not necessarily limited to: the Credentialing Committee; Peer Review Committee; Quality Improvement Committee; Utilization Management Committee; Regional Quality Assurance Representatives; Vice President of Professional Affairs; and the Director of Professional Services.
- Available to the Legal Department if required by a court officer.
- Security protected to prevent any tampering or misuse.

Davis Vision providers will abide by the Confidentiality Policy of Davis Vision contained in their Provider Manual. Furthermore, providers will:

- Prevent unauthorized access to member records.
- Place all Davis Vision member records in a secure location that will limit access to authorized personnel only.
- Identify the position and identity of authorized personnel who have access to patient care records.
- Retain patient and financial records in accordance with state and federal requirements.

Further, in those instances where Davis Vision needs to obtain patient-specific information from a provider or other healthcare entity it shall abide by its own confidentiality policy:

- Upon calling for patient information the Davis Vision associate will identify themselves by name, title and department.
- If further verification is required, Davis Vision will provide the request in writing or the entity may call the associate back.

Although the records are the property of the provider and/or Davis Vision, patients have the right to examine their records and to copy and/or clarify information contained in them. Accordingly, for the above listed reasons, members authorize the sharing of medical information about themselves and their dependents between Davis Vision and participating providers. Davis Vision's Confidentiality Policy is available to any member, patient, provider or group upon request.

PRESCRIBING AND REFERRALS

It is the policy of Davis Vision that providers have the right to prescribe eyewear or recommend treatments and follow-up care and make appropriate referrals based on their professional judgment and scope of their license. It is also policy that any such referrals be made to fellow practitioners within the Davis Vision provider network who have therefore also demonstrated adherence to our specific credentialing standards with the exception of in cases of medical emergency, on the basis of no qualified provider being available within the network, where the patient's benefit program permits selection of out-of-network providers and they wish to do so, in cases where continuity of care with a non-participating practitioner is clinically warranted, or in cases where required by state or federal law or regulation.

Davis Vision's policy on referrals requires providers to inform members in regards to why the referral is needed, the importance of follow-up care and the possible consequences if the member fails to comply with the recommendation. Members have the right to refuse treatment. In the event that the practitioner's recommendations exceed the limitations of the member's benefit through Davis Vision, members will be instructed to contact their medical carrier for verification of eligibility and confirmation of protocols.

Patients should clearly be informed of any additional tests and the associated fees recommended by their provider. If a patient is to pay directly for any services, they must be informed in advance. Written confirmation of recommendations is strongly advised. Please note that some tests may require a referral from a Primary Care Physician (PCP). Written consent from the patient is advised when transferring clinical information to another provider.

CONTINUITY OF CARE

Doctors whose offices may be closed for three months or longer due to vacation, illness or other circumstances should inform Davis Vision. Arrangements for the dispensing of ophthalmic materials and continuity of care during any temporary lapse in office hours or permanent closure must be made. Patient records needed to ensure continuity of care should be made available to the accepting provider with the member's consent. Patients retain the right to choose a new provider.

PAIN MANAGEMENT

Davis Vision providers must recognize that members' pain must be assessed and managed. Providers will prescribe appropriate pain management that is within the scope of license. Providers who are not licensed to prescribe adequate pain management must refer the patient to an appropriate licensed professional.

CONSISTENCY AND ERROR AVOIDANCE

In as much as certain National Patient Safety Goals set by JCAHO and the development of specific patient safety related standards set by NCQA pertain to the eye care services Davis Vision provides, the company is committed to improving the accuracy of patient identification, improving the effectiveness of communication among caregivers, including thorough review of their credentials to ensure a high quality delivery system, eliminating wrong-patient/wrong-procedure practices and reducing the risk of health care-acquired infections.

Patient identification includes a verification process between the provider and patient prior to an examination being given, including confirmation of the patient's name, member identification number and birthdate. All of these items are necessary for completion of the service record form before services may be rendered. This serves well as an identity measure.

Davis Vision strives to improve upon all areas of vision care services provided to members from the administration of paperwork to the coordination of the manner in which our providers conduct examinations and keep patient information. In order to improve upon the communication among the providers the RQARs conduct site surveys of provider offices where record keeping is evaluated, among other items. These evaluations are compiled and studied for consistency among providers and to see if there are trends or patterns that need to be addressed including the incorrect or inconsistent use of diagnosis codes.

Although it is unlikely that there would ever be a time or situation where certain eye care services would be performed on the wrong patient or perhaps the wrong eye it is obviously a priority for Davis Vision to make sure such a situation does not arise. All providers are advised to keep detailed records of all procedures performed, or to be performed, and to consult with the patient about what is being done before it is performed.

To this end Davis Vision is cognizant at all levels of patient service to maintain accuracy thus preventing any type of patient error. This includes order receipt and entry of eyeglass and/or contact lens prescriptions. The wrong prescription for the wrong eye or incorrect prescription overall can be just as harmful to a patient as any hands-on examination or procedure. Davis Vision has exhaustive procedures and policies in place with regard to training the member service representatives (MSRs) responsible for order entries into our computer system in order to eliminate, or at the very least minimize, prescription error.

Whether an order for lenses is faxed, phoned in or input via the Davis Vision website it is verified and subject to review and recording for quality assurance before the order is even

invoiced. Reviewers verify each element on a faxed or website order, including of course the provider's name and pertinent information, the patient's name and the prescription. The provider is called if any information is missing or appears incorrect. During phone orders a read back to the provider of the complete order is performed and verification of the provider's name and patient's name and identity is completed. All incoming and outgoing calls received in the call center are digitally recorded and verified before the order is invoiced.

PATIENT SAFETY

Safety issues involved in patient care are of the highest concern in this day and age and as a result Davis Vision has adopted the implementation of certain safety goals. Many of these goals are JCAHO-established and comply with the Center for Disease Control (CDC) guidelines. As part of Davis Vision's patient safety program, it is expected that provider offices will be in compliance with reasonable safety precautions to effectively minimize risk of members sustaining any injury. Ensuring patient safety also includes indications of emergency preparedness, such as clearly marked exits and the presence and operational efficiency of smoke/fire detectors and/or fire extinguishers.

The safety of the member includes compliance with medication safety. Medication should be:

- Secured
- Properly labeled with an expiration date indicated
- Dispensed within the proper timeframe (i.e., dispensed well in advance of the expiration date)

Prior to administering any medication it is recommended that providers review/confirm the members:

- Allergy History
- Current Medication
- Significant medical history
- Significant ocular history

In addition, Davis Vision is very cognizant of adhering to specific guidelines for infection control. In this respect our providers are expected to comply with current CDC hand hygiene guidelines.

Infection control measures (adopted from the Center for Disease Control) are to be adhered to by all providers. Infection Control protocols can be found further on in this manual and include:

- Staff education and Infection Surveillance
- Hand Washing and use of Gloves (latex or latex free)
- Disinfecting procedures for equipment and supplies
- Reporting of Infections

As part of an overall program to improve hand-hygiene practices of providers, education is encouraged for personnel about types of patient-care activities that can result in hand contamination and advantages and disadvantages of various methods used to clean their hands.

Providers are expected to wash their hands prior to any patient examination or procedure with antimicrobial soap and water in all clinical situations before having direct contact with patients. Following this, providers are to decontaminate hands after contact with inanimate objects such as medical equipment in the immediate vicinity of the patient. Providers are advised to wear gloves when contact with blood or other potentially infectious materials, mucous membranes and nonintact skin could occur. Gloves should be removed after caring for a patient and decontamination of the hands should take place after removing gloves. The same pair of gloves should not be worn for the care of more than one patient.

RQARs are instructed during on-site visits to provider offices to observe the general facility appearance and with regard to infection control and hygiene that there are sinks available for hand decontamination prior to patient examinations.

FULL PATIENT DISCLOSURE

Davis Vision does not prohibit or restrict providers from disclosing to members information regarding a condition or course of treatment, the availability of therapies (whether they are included as a covered benefit or not), consultations or tests and/or the terms of the plan's benefit as they relate to the member. Providers are not restricted from filing a complaint or making a report to an appropriate governmental body regarding policies and practices the provider believes may negatively impact the quality of or access to patient care, nor does Davis Vision prohibit or restrict a provider from advocating on behalf of the member for approval or coverage of a course of treatment.

EMERGENCY CARE PROVISIONS

Emergency care may be necessary should a prudent layperson feel that a delay in services might compromise their health. Members are advised that emergency care should never be postponed, and these services may require members to follow the protocols of their major medical carrier. Patients may require and receive urgent care not subject to prior authorization. This, however, does not imply coverage by Davis Vision for such care. Individual doctors may give specific instructions to patients in such situations. In addition, Davis Vision maintains a toll-free hotline for all patients. This telephone line is staffed 24-hours a day, seven days a week. There is no additional cost for accessing the emergency hotline and prior approval is not required. Reimbursement for emergency services will be solely dependent on whether the patient is eligible for the benefit.

REFUSAL OF CARE

Davis Vision's patients have the right to refuse treatment. Members who are of legal age have the right not to comply with recommended treatment. Patients are to inform providers of their

decision. Davis Vision's practitioners will inform the member of any potential consequences resulting from such decisions.

All Davis Vision providers shall document in the patient care record when a patient refuses the recommended course of treatment. Documentation should include the treatment recommendations and the reasons for refusal and the consequences that may develop as a result of the patient's decision. Patients must be made aware of the implications relating to non-compliance and refusal to accept the treatment plan. Providers should make a reasonable effort to have the member acknowledge their refusal of care, and at a minimum, it should be noted in the member's record.

INFORMED CONSENT

Patients (and their families when appropriate) have the right to know all options, therapies, treatments and services regardless of any restrictions imposed by the vision care plan. Practitioners should not be deterred or constrained from presenting these options to the patient. The Patient's Bill of Rights entitles the patient access to information on services available, including treatments that may exceed that allowed under the Davis Vision benefit plan. Patients have the right to receive all the information needed to give informed consent for any proposed procedure or treatment. This information shall include the possible risks and benefits of the procedure or treatment. Patients are expected to provide all necessary information to providers to facilitate effective treatment.

Practitioners are expected to involve members in all aspects of treatment, care, and service. To support their involvement, members are given a clear, concise explanation of:

- Their condition and proposed treatments or procedures
- The potential benefits and risks of proposed care
- Problems related to adaptation and recovery
- The likelihood of success
- The probable consequences of refusing treatment or failing to cooperate with therapy
- Their right to refuse treatment
- Any significant alternative treatments or procedures

Davis Vision's practitioners will respect all psychosocial, cultural and spiritual values when implementing a mutually agreed upon plan of care. Discussion will be in a language and in a manner that will provide the patient a full understanding. When warranted the provider should refer the patient to an appropriate professional for further care.

SELF DETERMINATION

Although unusual for eye care practice, Davis Vision recognizes that patients have the right to be informed of the Federal Self Determination Act. Davis Vision will not refuse to treat a patient who has executed an Advanced Directive.

Members have the right to:

- Make medical decisions
- Accept or refuse treatment, including the right to refuse life-sustaining medical and surgical treatment
- Make advanced directives about their medical care in the event that they lack the capacity

Davis Vision's practitioners will refer all members to their Primary Care Physician for guidance.

INVESTIGATIONAL STUDIES

It is the policy of Davis Vision that members have the right to refuse to participate in research and/or investigational studies. Investigational or experimental treatment is described by Davis Vision as:

An unapproved ocular diagnostic procedure warranted by the ocular health of the member and the subsequent diagnostic findings could alter the member's treatment plan. The risk of a negative outcome utilizing the approved treatment would be no greater than utilizing an alternative treatment.

Although Davis Vision does not participate in investigational studies it does not prevent independent providers from participating in such studies. Services and care associated with investigational studies are funded separately by the sponsored research program. It is Davis Vision's policy that all participating providers who do participate in and conduct independent studies will:

- Inform the member of the purpose of the study
- Inform the member that they have the right to refuse to participate
- Inform the member how collected data will be utilized
- Inform the patient of all associated risks and/or benefits
- Inform the patient of all associated costs
- Obtain written consent from the patient
- Ensure that all information will be kept confidential
- Provide patients with a written description of the study in a language and level understood by the member

Services performed, as part of an investigational study may not be billed under a Davis Vision program.

RESEARCH

Davis Vision, a leader in vision care, continually reviews information that may lead to better vision care and the prevention of eye disease.

Davis Vision collects utilization trend data as an integral aspect of our Quality Improvement program. This data collection can include, but is not limited to:

- Dilated Fundus Examinations
- Pediatric care
- Safety eyewear use
- Medical eye care
- Medically necessary contact lenses

Patient and provider surveys are also conducted in order to improve care.

PATIENT SATISFACTION FORM

Davis Vision's Quality Improvement program includes member satisfaction surveys. A patient satisfaction survey is an opportunity for members to assess accessibility, standards of care and treatment, as well as the professional interaction that occurred during an encounter. Members can indicate their perception of the care and education received. These results are collected, aggregated and analyzed by Davis Vision. Davis Vision utilizes this data in various ways, such as during the recredentialing process. Panel doctors will semiannually receive comparative statistics for their office based on surveys returned.

Surveys that contain a concern or complaint are always investigated to determine if there is an opportunity for Davis Vision to improve service. When an opportunity is identified, the Quality Assurance Department as well as the Vice President of Professional Affairs and Quality Management is notified. When indicated, providers will be asked to respond to concerns raised by members. The results of these surveys may be shared with the Regional Quality Assurance Representative, the Quality Improvement and Utilization Review Committees.

MEDICAL NECESSITY

All services submitted for consideration to be paid as a result of medical necessity are assessed by Davis Vision on an individual basis. The standards and criteria used in determining whatever prescribed services are medically necessary are compared annually to the national medical policies used by the Medicare program. These policies identify those ICD-9-CM diagnostic codes that support medical necessity.

Davis Vision will monitor and review clinical practice guidelines promulgated by the American Optometric Association to determine whether changes or modifications are warranted. These criteria have been reviewed by Davis Vision's Utilization Review and Quality Assurance committees and are continuously reviewed for timeliness.

Although Medicare does not cover refractive care these services are covered by the basic benefit plan of Davis Vision. When medical services are covered within the benefit plan the service is reasonably expected to do one of the following:

- Prevent the onset of an illness, condition or disability

- Reduce or ameliorate the physical, mental, or developmental effects of an illness, condition, injury or disability
- Assist the individual to achieve or maintain maximum functional capacity in performing activities of daily living
- Assist in diagnosing an illness or condition

Assessment for medical necessity includes an assessment of the individual's needs including but not limited to status, co-morbidities, psychosocial, environmental, special needs; response to treatment; and prior use of diagnostic services, if applicable.

Documentation supporting the medical necessity maintained in the patient's medical report must be made available to Davis Vision upon request so that a determination may be made.

Clinical reviewers refer to Davis Vision's policies in determining medical necessity. When in the professional judgment of the Davis Vision reviewer the requested service or item is medically necessary, the reviewer may override any criteria to the contrary. All reviewers are instructed that they may make this determination. All reviewers are licensed clinical practitioners who have no incentive in restricting or limiting services by plan members.

MEDICALLY NECESSARY CONTACT LENSES

Some plans include enhanced coverage for medically necessary contact lenses. Contact Lenses may be determined to be medically necessary and appropriate in the treatment of patients affected by certain conditions. In general, contact lenses may be medically necessary and appropriate when the use of contact lenses, in lieu of eyeglasses, will result in significantly better visual acuity and/or improved binocular function, including avoidance of diplopia or suppression. Contact Lenses may be determined to be medically necessary in the treatment of the following nine (9) conditions:

Keratoconus

- Diagnosis confirmed by keratometric readings and observations, Placido disc or corneal topography
- Best correctable visual acuity with spectacles of 20/40 or less in either eye
- At least two lines improvement in best correctable visual acuity (as measured with standard Snellen chart) with rigid contact lenses
- Intact corneal epithelium
- Absence of corneal hydrops

Aphakia

- Aphakia in one or both eyes of congenital, surgical or traumatic etiology without implantation of an intraocular lens
- No corneal or vitreous opacities along the visual axis
- Intact macula
- Best correctable acuity of 20/100 or better
- Intact corneal epithelium

Anisometropia

- ≥ 4.00 diopters difference in prescription (spherical equivalent) between right and left eyes
- Best correctable acuity of 20/40 or better in the better eye
- Intact corneal epithelium

Aniseikonia

- Unequal image size between right and left eye resulting in intermittent or constant diplopia, suppression or binocular rivalry, or less than 100° steropsis
- Intact corneal epithelium

Pathological Myopia

- Myopia >8.00 diopters in one or both eyes
- Intact corneal epithelium

Aniridia

- Aniridia of congenital, surgical or traumatic etiology in one or both eyes
- Intact corneal epithelium

Corneal Disorders

- Any condition of congenital, pathological or surgical etiology causing compromised integrity of the corneal curvature or media resulting in best correctable acuity of 20/70 or less with spectacles in one or both eyes
- Corneal opacification
- Intact corneal epithelium

Post-Traumatic Disorders

- Any condition of traumatic etiology causing compromised integrity of the corneal curvature or media resulting in best correctable acuity of 20/70 or less with spectacles in one or both eyes
- Corneal opacification
- Intact corneal epithelium

Irregular Astigmatism

- ≥ 2.00 diopters of astigmatism in either eye where the principal meridians are separated by less than 90°, resulting in best correctable acuity of 20/70 or less in the affected eye with spectacles
- At least two lines improvement in best correctable visual acuity (as measured with standard Snellen chart) with rigid contact lenses

Utilization review shall not be conducted more frequently than is reasonably required to assess whether the services under review are medically necessary.

PRIOR APPROVAL

When requesting Prior Approval for Medically Necessary services, the provider should complete a Prior Approval Form (Attachment "14"), including at a minimum the following information:

- Member's and/or patient's identification number
- Patient's name
- Requested service or procedure
- Diagnosis
- Justification

The Prior Approval Form must be faxed to the Davis Vision Prior Approval Department at (800) 584-2329. A Davis Vision Prior Approval representative will review each request. Authorization for services, treatment or procedures will be issued by telephone and in writing within two (2) business days of the receipt of necessary information if the request is a covered benefit or medically necessary. Approval authorization is entered in CompuVision™. The Vice President of Professional Affairs and Quality Management reviews all denied requests. As part of the Vice President's review, the practitioner may be contacted to discuss the case. All approvals are communicated to the network provider who communicates the decision to the member and/or patient. The provider and member are notified of any denials in writing according to the specific Plan protocol. Requests that are denied based on medically necessary criteria will comply with Davis Vision's Member Appeal Process. Davis Vision will notify the provider and member via mail and will supply the following information:

- Criteria that was utilized, including the clinical rationale, if any, and the documentation supporting the decision
- Statement indicating that the decision will be final and binding unless the member appeals in writing to the Quality Assurance/Patient Advocate Department within 45 days of the date of the notice of the decision
- Copy of Davis Vision's Appeals Process, if applicable
- The decision of the Quality Assurance/Patient Advocate Department shall be final and binding unless appealed by the member to Davis Vision within 45 business days of the date of notice of the decision
- Name, position, and phone number and department of person(s) who was responsible for the outcome

In some cases, a client, plan or regulatory agency may mandate a specific appeal process. For all other members, Davis Vision's standard process will apply as outlined below.

MEMBER APPEALS PROCESS

It is Davis Vision's policy to ensure thorough consideration of membership benefits. Utilization reviews and appeals are conducted within specific time frames to assure timely determinations. In the event that a claim(s) is adjudicated and payment is not made, Davis Vision will consult with the provider who coordinated/administered the member's vision care treatment. Should a mutual agreement not be achieved, the provider and/or patient have the right to request a review of the adverse determination. The provider, member or patient may appeal denied prior authorizations or claim decisions. Should a member choose to appeal a prior authorization or claim decision, Davis Vision will acknowledge the member, or designee, within five (5) business days of receipt of the request and the review will be conducted by a clinical peer who was not involved in the original vision care determination. Pre-service review decisions are to be completed within fifteen (15) days of receipt of required information and retrospective (post-service) review decisions are to be completed within thirty (30) days of receipt of required information, or as required by state statute from the date that the notice was received by Davis Vision from the member or their designee and be mailed within five (5) days of the decision date. Denials can be appealed through Davis Vision's Grievance Resolution Process or as per plan contract. Members have the right to appeal through an external review organization at any time during the grievance process. Members have the right to designate a representative, including their provider, to act on their behalf with regard to review of a vision care claim determination. Participation in the aforementioned process shall not be deemed to be an abrogation of the members' legal rights and Davis Vision recognizes the fact that a member may have other or additional recourse depending on their state of residence.

MEMBER GRIEVANCE PROCESS *

***** For the New York State, or your state-specific Managed Care Complaint, Grievance and Appeals Process, if applicable, please see Attachment "15".

REGISTERING A COMPLAINT OR GRIEVANCE

Davis Vision members have the right to voice a complaint or grievance or make an appeal to any claim decision at any time. Davis Vision will not retaliate or take any discriminatory action against any member as a result of filing a complaint, grievance or appeal and the member has the right to designate a representative to file on their behalf.

Members are entitled to a copy of the Grievance Resolution process upon request and a copy will be provided to Davis Vision members should vision care benefits not be available or prior approval requests are denied.

For those Members (of insured plans) residing in the Commonwealth of Virginia:

Virginia members may also contact the Center for Quality Health Care Services and Consumer Protection Complaint Unit for assistance with quality of care complaints.

In writing: Center for Quality Health Care Services and Consumer Protection
Virginia Department of Health
3600 W. Broad Street, Suite 216
Richmond, VA 23230

Toll free: 1-800-955-1819
Richmond metropolitan area: 804-367-2104
Fax: 804-367-2149
E-mail: mchip@vdh.state.va.us

GRIEVANCE

While a "complaint" is simply a verbal or written expression of dissatisfaction Davis Vision defines a "grievance", also known as a complaint, as a verbal or written request for a review of claim denials, coverage determinations or contracted services that may or may not require specific corrective action. Grievances may be submitted in the following manner:

1. Via telephone
2. In writing to Davis Vision
3. Via the Davis Vision web site

As outlined above, a grievance or complaint can arise from, and includes but is not limited to, the following:

1. Benefit denials
2. An adverse determination as to whether a service is covered pursuant to the terms of the contract
3. Difficulty accessing or utilizing a benefit and/or issues regarding the quality of vision care services
4. Challenges with provided vision care services or products received
5. Dissatisfaction with the resolution of a previous grievance, i.e. "adverse determination".

VERBAL GRIEVANCES AND TELEPHONE COMMUNICATION

A member may file a verbal grievance by contacting Davis Vision. Registering a complaint or grievance utilizing the telephone will constitute filing a "formal grievance". A Davis Vision Associate will acknowledge receipt of all complaints by telephone or in writing within five (5) business days from the date the complaint, grievance or appeal is received.

Davis Vision members have access to the Davis Vision toll free number twenty-four (24) hours a day seven (7) days a week to voice any concern or grievance and also have the right to contact

their Human Resources Department or Benefits Administration Department. The Davis Vision Toll Free number is: **1-800-584-1487**

TELEPHONE COMMUNICATION

Davis Vision members have access to the Davis Vision toll-free number twenty-four (24) hours a day, seven (7) days a week to voice any concern or grievance to appropriate staff members responsible to the Quality Assurance or Utilization Review Committees. Members also have the right to contact their Human Resource Department or Benefit Administration Department.

The Davis Vision toll-free number for filing grievances is: **1-800-584-1487.**

WRITTEN GRIEVANCES

Written notices of grievance received via e-mail, U.S. Mail or other written correspondence will be acknowledged within five (5) business days. All written correspondence should be addressed to:

Davis Vision
159 Express Street
Plainview, New York 11803
Attention: Quality Assurance/Patient Advocate Department

Davis Vision members can register any concern or grievance by logging on to our web site at **www.davisvision.com** and entering the "Contact Davis Vision" area.

INTERNAL GRIEVANCE PROCEDURE

APPEAL LEVEL 1

Upon receipt of a concern or grievance by a Davis Vision Associate, the member is contacted by telephone or in writing within five (5) business days to confirm that the concern or grievance was received and is being investigated. It is Davis Vision's policy to make every attempt to contact the member or their designated representative. Contact may include, but is not limited to, telephone, e-mail or US Mail. A designated Davis Vision Associate reviews the appeal, defined as a verbal or written request to change a determination previously made by Davis Vision, with the member and may request additional information. Details of the complaint are documented in the member's file. Davis Vision members are asked for their expectation in resolving the concern. Members are provided with the Associate's name, phone number, department and the estimated time needed to perform the research (for pre-service appeals 15 days of receipt of required information and post-service appeals 30 days of receipt of required information) in which they can expect a determination. Members are informed of their right to have a representative, including their provider, present during the review of the concern and final outcome of the investigation. Members are informed of their right to appeal to an external review organization at any time during the grievance procedure or as required by state statute.

When grievances pertain to clinical decisions the review committee will include a licensed (peer) health care professional. All decisions are reviewed and approved by the Vice President of Professional Affairs and Quality Management, a licensed optometrist.

The investigation may involve contacting the provider or the point of service location to determine the root cause of the concern. When warranted, the Regional Quality Assurance Representative (RQAR) or Professional Field Consultant (PFC) will be contacted and a site visit may be scheduled. Davis Vision will contact the member when further information is required and to inform them of the status of the investigation.

The determination will be made within fifteen (15) days for pre-service review decisions and within thirty (30) days for post-service review decisions, or as required by state statute. An additional ten (10) days may be requested in order to complete further research. The written decision will be mailed to the member within five (5) days of the decision. The appeal determination will include the following:

- Outcome of the investigation, including a summary of the material facts related to the issue
- Criteria that was utilized including the clinical rationale, if any, and a summary of the evidence, including the documentation supporting the decision
- Statement indicating that the decision will be final and binding unless the member appeals in writing to the Quality Assurance/Patient Advocate Department within fifteen (15) business days of the date of the notice of the decision
- Copy of the appeals process, if applicable
- Name, position, phone number and department of the person(s) who was responsible for the outcome

The decision of the Quality Assurance/Patient Advocate Department shall be final and binding unless appealed by the member to Davis Vision within fifteen (15) business days of the date of notice of the decision.

If an adverse determination is made without attempting to discuss such matters with the provider who recommended the services, such provider may request re-consideration. This shall occur within one (1) business day of receipt of the request. An expedited appeals process for adverse determinations of continued or extended services may be requested. Expedited appeals shall be determined within two (2) days of receipt of required information and a clinical peer reviewer shall contact the provider within one (1) business day.

APPEAL LEVEL 2

Should Davis Vision uphold a denial as the result of a Level 1 Appeal, members have the right to request a Level 2 Appeal.

A Level 2 Appeal will not include Associate(s) or licensed (peer) health care professional(s) that were involved in the Level 1 review.

A Level 2 Appeal requires members to contact Davis Vision in writing or by telephone within fifteen (15) business days following the member's receipt of the Level 1 summary statement. Resident members in the state of Louisiana have thirty (30) days to contact Davis Vision. Members requesting a Level 2 Appeal must indicate the reason they believe the denial of coverage/benefit was incorrect. Davis Vision reserves the right to solicit further information from the member and/or provider.

Davis Vision has thirty (30) days, or as required by state statute, from the date the requested information is received, to respond to the Level 2 pre-service Appeal. Davis Vision has forty-five (45) days, or as required by state statute, from the date the requested information is received to respond to the Level 2 post-service Appeal. The Vice President of Professional Affairs and Quality Management will review all clinical appeals. A Davis Vision Associate(s) and a Regional Quality Assurance Representative(s) (RQAR), a licensed optometrist, not involved in the initial determination will review the Level 1 decision. If the Level 2 Appeal upholds the Level 1 determination the member will be notified in writing of this decision. The written decision will be mailed to the member within five (5) days of the decision. Notification will include, but not be limited to:

- Outcome of the investigation, including a summary stating the nature of the concern and the material facts related to the issue
- Criteria that was utilized, and summary of the evidence, including documentation that was used to support the decision
- Statement indicating that the decision will be final and binding unless the member appeals in writing or by telephone to the Quality Assurance/Patient Advocacy Department within forty-five (45) business days of the date of the notice of the Level 2 decision
- Copy of the appeals process, if applicable
- Name, position, phone number and department of person(s) who was responsible for the outcome

EXTERNAL GRIEVANCE PROCEDURE

EXTERNAL REVIEW

While Davis Vision's external review process is available to all members, if you are a member under a self-insured plan, the plan sponsor may have its own appeals process that would preclude the use of the following external process, however, if such a process does not exist then the following would apply.

As required by state statute, Davis Vision affords its members an opportunity to request an impartial review of concerns that resulted in coverage denials. Members who have utilized and

exhausted the internal appeals process may appeal the final decision if the denial was not deemed medically necessary or the requested service was deemed Investigational or Experimental.

An external review organization will refer the case for review by a neutral, independent practitioner experienced in vision care. Davis Vision will provide all requested documentation to the external review organization. The external review organizations will have up to thirty (30) days or a time period required by state statute to make a determination.

Davis Vision, a national provider of vision care benefits, recognizes that many states implement an external review process that is unique to their residents. Individual states have mandated the use of their own external review process for appeals based on medical necessity. Davis Vision members can call our Member Service Department for information unique to their state of residence. Members also have the right to contact their state insurance or health department for further information.

For those Members (of insured plans) residing in the Commonwealth of Virginia:

Virginia members may have the right to request an independent external appeal through the External Appeals Section at the Bureau of Insurance.

If the member meets the definition of an appellant, and a request for approval of vision care service(s) has been denied, the member may have the right to an external review of Davis Vision's decision. An impartial health entity selected by the Bureau of Insurance will review the appropriateness of Davis Vision's decision, and shall make a recommendation to the Commissioner of Insurance as to whether the vision care service(s) should be covered. In order for such a review to occur, the member (appellant) must complete and sign an APPEAL OF FINAL ADVERSE DECISION FORM which Davis Vision will obtain from the State Corporation Commission, Bureau of Insurance, External Appeals, P.O. Box 1157, Richmond, Virginia 23218, (804) 371-9913 and provide to the member.

Additionally, the appeal in question must meet the following criteria:

1. The cost of service in question must exceed $300;
2. The appeal must be filed within 30 days of the final adverse decision by Davis Vision;
3. Davis Vision's internal appeal process must have been exhausted (except for expedited reviews); and
4. A $50 filing fee may be required

EXTERNAL REVIEW PROCESS

Davis Vision members have the right to an external review of a denial of coverage. Davis Vision's members have the right to an external review of a final adverse decision under the following circumstances:

- The member has been denied a vision care service that should have been covered under the terms of the contract.
- Services were denied on the basis that requested services were not medically necessary.
- A treatment or service that will have a significant positive impact on the member has been denied and any alternative service or treatment will not affect the member's ocular health and/or produce a negative outcome.
- Services denied are related to a current illness or injury.
- The cost of the requested services will not exceed that of any equally effective treatment.
- The denied service, procedure or treatment is a covered benefit under the member's policy.
- Member has exhausted all internal appeal processes with an Adverse Determination upheld at each level.

The vision care provider and/or Primary Care Physician may contact the appropriate State Agency to determine if other documentation may be required for the appeal process.

The External Review representative must make a decision within thirty (30) days of receipt of documentation, or as required by state statute, and will notify the member within two (2) business days of a determination. Notification must be in writing and include an explanation and the clinical criteria utilized in the decision.

SENTINEL EVENT

The majority of services that Davis Vision provides to its members are limited to routine vision care and as such, the possibility of a Sentinel Event is rare. Medical eye care services are funded under several plans, but remain a small portion of all care rendered under Davis Vision's programs. Davis Vision defines a Sentinel Event as an unexpected response during or in response to an ocular examination or procedure. A Sentinel Event as defined by the Joint Commission on Accreditation of Healthcare Organizations is an "unexpected occurrence or the risk thereof". The phrase "or the risk thereof" includes any process for which a recurrence would carry a significant chance of a serious adverse outcome. Davis Vision recognizes that reactions can occur at any time; however, measures should be taken to prevent such an occurrence or a reoccurrence.

Davis Vision has identified the following as processes that may predispose members to adverse outcomes in response to care:

- Acute Angle Closure Glaucoma (during dilated fundus examinations)
- Syncopical episodes, resulting in the need for medical intervention occurring:
  - During a comprehensive eye exam, or contact lens fitting or;
  - Pre, and/or post operatively or;
  - Trauma-induced injuries as a result of falls or other circumstances resulting in emergency medical treatment at a hospital facility.
- Severe Allergic Reactions

- Anaphylactic shock

The goal of Davis Vision's Sentinel Event Policy is to minimize adverse consequences and to provide a positive impact on patient care. A Sentinel Event in any organization presents an opportunity for an investigation that will analyze current clinical practices and/or processes that may have contributed to the event. A comprehensive review may determine underlying contributing factors that impact the outcome. Identification of those factors may assist in the redesign of the process and ultimately reduce the risk for other patients.

In the event of a possible Sentinel Event, practitioners are required to report the event to Davis Vision within seventy-two (72) hours. Davis Vision will then initiate a root cause analysis of the incident. The analysis will focus on the process and all of the circumstances that led up to the event. Once a comprehensive analysis has been completed an action plan will be implemented. A completed report will be maintained by Davis Vision and will include, but not be limited to:

- A description of the event
- A root cause analysis of the contributing factors associated with the event, including the identification of the processes that led to the event
- An action plan detailing the implementation process that will reduce the risk or consequences of a reoccurrence
- Relevant literature search material that was used to benchmark improvement strategies, goals and timetable for reviews and reports
- Revisions in policies, procedures and/or processes
- Identification of associates involved in monitoring the process

INFECTION CONTROL STANDARDS

Preventing and controlling the risk and transmission of microorganisms in patient care settings is essential. Cross-infection is the process of acquisition by staff and/or other patients of pathogenic microorganisms from other staff or patients. This process carries the potential for harm due to actual infection by such pathogenic organisms. It is important to be aware that a patient need not be experiencing active illness in order to be a hazard to others.

Providers should implement all infection control processes consistent with federal and state regulations to reduce the risk of infections in patients and employees.

All providers are responsible for ordering isolation precautions for patients in their care as soon as a communicable pathogen is documented.

STAFF EDUCATION AND INFECTION SURVEILLANCE

All office staff should be educated regarding an infection surveillance and infection control procedures.

Staff should be aware of their immunization status as it pertains to frequently encountered communicable patient illnesses and maintain their immunization status, as required by state and local regulations.

The potential presence of pathogen microorganisms in blood, body fluids and tissues of patients may be harmful, even though the patient from whom these materials are derived may not be considered to have a communicable disease. All staff having contact with such materials, either routinely or under unusual but predictable circumstances should be mindful of this possibility.

UNIVERSAL PRECAUTIONS

Universal precautions and the use of interactive networks should be employed when caring for patients.

Universal precautions are intended to supplement rather than replace recommendations for routine infection control, such as hand washing and using gloves to prevent gross microbial contamination of hands.

Hand washing between patients and after contact with blood or bodily fluids and equipment used in patient examination is essential in order to reduce the risk of transmission of microorganisms.

All professionals and support staff personnel must routinely use appropriate barrier techniques to prevent skin and mucous membrane exposure when contact with blood or other body substances of any patient is anticipated.

HAND WASHING AND USE OF GLOVES

Hands and other skin surfaces must be washed immediately and thoroughly if contaminated with blood and other body substances. Hands must be washed immediately after gloves are removed.

The Center for Devices and Radiological Health of the Food and Drug Administration (FDA) has responsibility for regulating the medical glove industry. There are no reported differences in barrier effectiveness between intact latex and intact vinyl materials used to manufacture gloves. Thus, the type of gloves selected should be appropriate for the task being performed. Patients should be asked whether they are known to be allergic to latex gloves.

The following general guidelines are recommended:

- Use sterile gloves for procedures involving contact with normally sterile areas of the body.
- Use examination gloves for procedures involving contact with mucous membranes, unless otherwise indicated, and for other patient care or diagnostic procedures that do not require the use of sterile gloves.
- Change gloves between patient contacts.
- Do not wash or disinfect surgical or examination gloves for reuse. Washing with surfactants may cause "wicking" (i.e., the enhanced penetration of liquids through undetected holes in the glove). Disinfecting agents may cause deterioration.
- Use general-purpose utility gloves (e.g., rubber household gloves) for housekeeping chores involving potential blood contact and for instrument cleaning and decontamination procedures. Utility gloves may be decontaminated and reused but should be discarded if they are peeling, cracked, or discolored, of if they have punctures, tears or other evidence of deterioration.

EQUIPMENT AND INSTRUMENTS

Compliance with universal precautionary measures for the disinfection and sterilization of medical devices should be monitored. All contaminated equipment and instruments should be thoroughly cleaned and disinfected after direct contact with a patient. Appropriate supplies and instructions for cleaning and disinfecting the equipment and instruments should be available.

PREVENTION OF SHARPS INJURY

All health care workers must take precautions to prevent injuries caused by needles, scalpels and other sharp instruments or devices during procedures, when cleaning used instruments, during disposal of used needles and when handling sharp instruments after procedures.

To prevent needle sticks/puncture injuries, the following guidelines must be followed:

- Needles must not be recapped, purposely bent, broken by hand, removed from disposable syringes or otherwise manipulated by hand.
- All sharps must be placed in puncture resistant containers for disposal as close as practical to the use area.

USE OF RESUSCITATION DEVICES

To minimize the risks associated with emergency mouth-to-mouth resuscitation, disposable mouthpieces, resuscitation bags, or other ventilation devices should be available for use.

EMPLOYEES WITH COMMUNICABLE DISEASE OR SKIN LESIONS

Health personnel who have a communicable disease or infected skin lesion must refrain from all direct patient care and handling patient care equipment if direct contact transmits the disease until the condition resolves.

CONTACT LENS DISINFECTION

Although environmentally mediated mode of HIV transmission has not been documented, precautions should be routinely taken in the care of ALL patients.

The currently recommended standard sterilization and disinfection procedures for patient care equipment are adequate to sterilize or disinfect instruments, devices, or other items contaminated with blood or other body substances from persons infected with blood borne pathogens including HIV.

Instruments or devices that enter sterile tissue or the vascular system of any patient or any areas through which blood flows should be sterilized before reuse.

Devices or items that contact an intact mucous membrane should be sterilized or receive high-level disinfection.

Chemical germicides that are registered with the United States Environmental Protection Agency (EPA) as "sterilants" may be used for either sterilization or for high-level disinfection, depending on contact time.

Medical devices or instruments that require sterilization or disinfection should be thoroughly cleaned before being exposed to the germicide, and the manufacturer's instructions for the use of the germicide should be followed. Further, it is important that the manufacturer's specification for compatibility of the medical device with chemical germicides be closely followed.

Studies have shown that HIV is inactivated rapidly after being exposed to commonly used chemical germicides at concentrations that are much lower than used in practice. The standard procedure for cleaning instruments is to remove any organic matter by rinsing under running water and to disinfect with a ten (10) minute exposure to one of the following fresh solutions: (a) 0.5% solution (1/10 dilution) of common household bleach (sodium hypochlorite), (b) 3% hydrogen peroxide, (c) 70% ethanol or (d) 70% isopropyl alcohol. After instruments are disinfected with the above procedure, they should be rinsed thoroughly and dried before reuse**.**

Contact lenses used in trial fittings should be disinfected after each use by using a hydrogen peroxide contact lens disinfecting system. Another acceptable method of disinfection may include heating for ten (10) minutes.

HOUSEKEEPING

Extraordinary attempts to disinfect or sterilize environmental surfaces such as walls, doors and other surfaces are not necessary; however, cleaning and removal of soil should be done routinely.

Examination chairs and hard-surfaced flooring in patient care areas are usually cleaned on a regular basis and, as needed, when soiling or spills occur. Disinfectant detergent formulations registered by EPA can be used for cleaning environmental surfaces, and the manufacturer's instructions for appropriate use should be followed.

CLEANING AND DECONTAMINATING SPILLS OF BLOOD OR OTHER BODY SUBSTANCES

Chemical germicides that are approved for use as "hospital disinfectants" and are tuberculocidal when used at recommended dilutions can be used to decontaminate spills of blood and other body substances. To effectively decontaminate areas in which spillage of blood and/or other body substances has occurred, it is recommended that appropriate gloves and/or other protective items be worn during cleaning and decontaminating procedures. In patient care settings, visible material should first be removed and then the area should be decontaminated.

REQUIRED REPORTING OF COMMUNICABLE DISEASES

Providers should report the incidence or threat of any communicable infectious diseases to the appropriate agencies, as stipulated by statutes or regulations that require such notification be provided to the city and/or the state.

EXAMINATION AND DOCUMENTATION

Davis Vision's providers, by contractual agreement, must comply with the standards of care as detailed in the Provider Manual. Davis Vision has established standards for member assessment based on the guidelines of the American Academy of Ophthalmology and the American Optometric Association. These standards include guidelines for documentation, record maintenance and patient confidentiality.

A comprehensive ocular assessment will be performed (regardless of the patient's age or other factors) and will include history, examination results and the initiation of an individual treatment plan for patient care management. Each aspect of the assessment includes a series of relevant diagnostic procedures that assist the provider in detection and diagnosis and facilitate choosing an appropriate plan of care for the member's ocular, visual and, when indicated, systemic condition(s). The components of the basic history and assessment are not meant to exclude additional tests or procedures.

EXAMINATION

The comprehensive assessment evaluates the physiologic function and the anatomic structure of the eye. The general eye assessment should include, but not be limited to, the following:

- Assessment of current acuity, distance and near, using the member's present corrective lenses, if applicable
- External ocular evaluation including slit lamp examination
- Internal ocular examination*
- Tonometry
- Distance refraction – objective and subjective
- Binocular coordination and ocular motility evaluation
- Evaluation of pupillary function
- Biomicroscopy
- Gross visual fields

∗ *A Dilated Fundus Examination must be included whenever professionally indicated.*

Records must be written clearly so that they may be read by others. When an ophthalmic correction is recommended, it must be noted in the patient record, including prescription and dispensing information (glasses and/or contact lenses). The patient's vision care service record form shall be included as part of the patient record.

All eye examinations must meet any state regulations that may exist. In accordance with the rules and regulations of the Federal Trade Commission, a written eyeglass prescription must be issued to the patient upon completion of the examination if an ophthalmic correction is recommended. The patient record will contain the necessary documentation describing the member's outcome of the examination.

In addition, patients wearing contact lenses must be provided with a copy of their contact lens prescription immediately after a contact lens fitting is performed as stated in the Federal Trade Commission's *Fairness to Contact Lens Consumers Act*. The prescription may contain an expiration date according to specific state law but no less than one (1) year after the issue date of the prescription.

All Davis Vision providers are required to participate in the Quality Assurance Program. Providers are obligated by contract to allow inspection, auditing, and duplication of patient care records during on-site, off-site and peer or grievance reviews. Davis Vision must be permitted access to providers' offices for site visits. Providers must supply copies of requested clinical records in connection with such reviews. Providers are required to assist in the orderly transfer of patient care records, in a timely manner, if requested by the member.

DOCUMENTATION

Davis Vision's policy for the basic ocular and vision assessment includes maintaining the appropriate documentation in the member's record, which must include, at a minimum:

- Demographic information
- Chief complaint and history of current concern including any systemic conditions that are relevant to the eye examination
- Present status of current visual function including any recent changes in vision and the member's preferred corrective lenses (eyeglasses or contact lenses)
- Relevant past medical and surgical history
- Allergic reactions to medications
- Current medications
- Relevant family ocular history
- Social history: occupation, profession, avocation, hobbies
- Assessment and plan that is consistent with diagnosis
- Patient education when medically indicated and/or follow up
- Referrals to specialists or primary care physician (PCP)
- Preventive screening if appropriate
- Notation that patient was given appropriate care instructions or if patient refuses treatment he/she was made aware of the consequences
- Notation if other alternative treatment was offered
- Patient and/or designee signature
- Examining provider's printed name and signature

RECORD MAINTENANCE STANDARD

Complete patient records must be maintained in a secured location with access limited to authorized personnel. Test results for all procedures, including numeric findings must be entered in the record. Records of the exact lenses and frames and contact lenses dispensed should also be maintained. The patient's "Vision Care Service Record Form" when required, shall be included as part of the patient record and retained by the practitioner for ten (10) years (or number of years required by the specific Plan, whichever is greater). Providers must ensure that their medical record keeping practices, policies and procedures maintain patient confidentiality.

QUALITY OF CARE STANDARDS

The Davis Vision Quality Improvement Program continuously evaluates standards of care to ensure that our members experience the highest standards of quality of care. We take great pride in instituting standards for our organization that are consistent with those established by the National Committee for Quality Assurance (NCQA) and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). Our approach to quality care combines collection, aggregation and analysis of Quality Assurance indicators designed to enhance both provider and

plan performance. Our infrastructure, including our credentialing process, the Davis Vision management information system, and our comprehensive Quality Improvement Program distinguishes us as the preeminent vision care Preferred Provider Organization (PPO) acclaimed by our clients nationwide.

The Davis Vision Quality Improvement Program utilizes the traditional public health tenets of structure, process and outcome to monitor critical aspects of the delivery of care. The Quality Improvement Program entails an extensive and ongoing review of the following integral components of a vision care provider:

- Standards of care
- On-site peer review and audits
- On-site materials review and audits
- On and off-site record reviews
- Provider profiles and utilization review
- Patient satisfaction surveys
- Provider satisfaction surveys
- Member dissatisfaction log

STANDARDS OF CARE

All participating providers comply with detailed quality of care standards as set forth in our Provider Manual and through contractual agreement. Furthermore, providers are required to follow the clinical guidelines of the American Optometric Association and the American Academy of Ophthalmology. A complete description of the professional standards expected of all providers is detailed herein. The standards assure a level of service that is commensurate with high quality care and include requirements for:

- Instrumentation and Equipment
- Examination Procedures
- Dispensing Lenses
- Contact Lenses
- Prescribing and Referrals
- Continuity of Care
- Pain management
- Patient Safety
- Sentinel Event
- Infection Control
- Documentation Standards for Patient Records
- Patient Record Maintenance
- Office Confidentiality

INSTRUMENTATION AND EQUIPMENT

Each participating panel office must contain the following instrumentation and equipment to administer high quality and comprehensive examinations:

- Examination Chair
- Instrument Stand
- Acuity Chart/Slides/Cards
- Ophthalmoscope
- Retinoscope/autorefractor
- Phoropter
- Tonometer
- Trial Lens Set
- Trial Frame
- Lensometer
- Keratometer
- Biomicroscope
- Field Testing Equipment
- Color Vision Test
- Stereopsis Test
- Binocular Indirect Ophthalmoscope with appropriate lens

All instrumentation must be well maintained, properly calibrated and in good working order. Infection control measures must be incorporated into the maintenance of all equipment.

VDT EXAMINATION

When the VDT benefit is available in conjunction with a standard vision benefit and the examiner recommends a separate prescription for work/occupational usage, the occupational eyeglasses must differ from the standard pair in one of the following ways:

- Prescription difference of at least 0.50 diopter
- Different lens type, e.g., trifocal vs. bifocal
- Segment height difference of at least 5mm

Examinations must meet any state regulations that exist.

Refractive surgeons must in their documentation include appropriate pre- and post-operative clinical notes.

All eye examinations must meet any state regulations that may exist. In accordance with the rules and regulations of the Federal Trade Commission, a written eyeglass prescription must be issued to the patient upon completion of the examination if an ophthalmic correction is recommended. The patient record will contain the necessary documentation describing the member's outcome of the examination.

All Davis Vision providers are required to participate in the Quality Improvement Program. Providers are obligated by contract to allow inspection, auditing, and duplication of patient care records during on-site, off-site and peer or grievance reviews. Davis Vision must be permitted access to providers' offices for site visits, and the doctor must supply copies of requested clinical records in connection with such reviews. Providers are required to transfer patient care records, in a timely manner, if they are requested by the member to be sent to another provider of their choice.

DISPENSING

Dispensing will be performed by duly certified and licensed personnel (if required by state regulation) and include the following services:

- Frame selection - all appropriate plan frames will be shown and advice offered
- Fitting measurements - frame size, seg heights, etc.
- Ordering from central laboratories
- Verification of eyeglasses from laboratory for accuracy
- Adjusting eyeglasses for proper fit
- Follow-up adjustments

In accordance with the rules and regulations of the Federal Trade Commission, a written eyeglass prescription will be issued to the patient upon completion of the examination if an ophthalmic correction is recommended. The patient record will contain the necessary documentation indicating the outcome of the member's examination.

CONTACT LENS FITTING

In addition to those procedures performed as part of the conventional eye examination, contact lens fitting should include:

- Measurement of corneal curvatures
- Slit lamp examination of cornea
- The use of trial lenses if necessary
- One-on-one, hands-on instruction concerning insertion and removal of contact lenses
- Written instructions, upon delivery, for inserting and removing contact lenses at home
- Follow-up visits necessary to check lens fit and corneal integrity
- Provision of a written contact lens prescription in accordance with the Federal Trade Commission's *Fairness to Contact Lens Consumers Act*

SECTION IX
QUALITY IMPROVEMENT

Davis Vision's Quality Improvement Program incorporates elements of the Malcolm Baldrige criteria for Performance Excellence as well as the standards established by accrediting agencies, including the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and the National Committee for Quality Assurance (NCQA). Davis Vision's program was developed with the belief that Quality Improvement is not a technique, but a way of life for the entire organization. Davis Vision's Quality Improvement initiatives are patient-focused and based on the organization's Mission, Philosophy and Code of Ethics.

Davis Vision has assumed the responsibility for providing or arranging for the provision of vision care to its members and, as such, is responsible for the manner in which that care is delivered.

Davis Vision has demonstrated its ability to deliver and improve the quality of vision care received by its members by designing a collaborative Quality Improvement Program. In designing the program, Davis Vision focused on the definition of "quality care". The Institute of Medicine defines quality care as the "degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge".[1] In defining and evaluating quality care, Davis Vision has adapted the following crucial factors:

1. **Improving the Vision Health of its Members:** Through Davis Vision performance improvement program, mechanisms were developed and integrated throughout the network to continuously monitor performance. The planning and design of these system processes allows for real-time data analysis. The collection, aggregation and analysis of data obtained from all aspects of the network are critical to determine access, availability and timeliness of service, which directly impacts the health of Davis Vision's members.

2. **Patient Satisfaction:** A determinant of the quality of care the Davis Vision member receives is their perception on how the care provided addressed their needs. This process of analyzing member satisfaction is rooted in Davis Vision belief that a member's perception of quality care is a meaningful assessment of the care rendered.

3. **Professional Consideration:** Professional opinion addresses the technical skill required to administer care as well as the appropriateness of the care. Davis Vision's professional consultants provide input regarding the competency necessary to perform a treatment, thereby establishing and maintaining Davis Vision's qualifications for panel practitioners. Davis Vision values the opinion of its preferred panel and continuously surveys providers for their input and suggestions.

[1] Knight, Wendy, Managed Care, What It Is and How It Works, Aspen Publishers, Inc. Gaithersburg, Maryland, 1998 pgs. 195-223

Davis Vision was the sole recipient of New York's 1993-94 Governor's Excelsior or "Quality at Work" award, giving recognition to Davis Vision's commitment to quality care. Davis Vision's systematic approach to performance improvement is evident in the program's organization. The program's foundation is based on the concept that organization is the key element to the success of the program. Success of the Quality Improvement Program is evident in the organization of leadership, services, product development and process implementation. The intent of Davis Vision's Quality Improvement Program is to achieve and sustain significant and meaningful improvements in the care, services and support processes offered by Davis Vision. The program was structured to allow for a collaborative effort among leaders, associates, independent practitioners, components and members to quantify and qualify Davis Vision's performance to determine that our performance meets or exceeds standards of quality care and customer expectations. Davis Vision defines performance by monitoring processes and determining the level of member satisfaction.

QUALITY IMPROVEMENT PROCESS

MISSION STATEMENT

In support of Davis Vision's corporate values, vision, and business ethics, development and improvement are continuously sought. The intent of the Davis Vision Quality Improvement Program is to continually monitor and evaluate emerging trends in vision care, identify business opportunities in order and to continually improve patient outcomes. The Quality Improvement Process incorporates outcome data analysis to determine whether there is a need to provide new services, incorporate changes in existing protocols or develop new policies and procedures.

OBJECTIVE

To collect, aggregate and analyze data on functions, processes and outcomes of services provided by Davis Vision. Davis Vision continuously monitors performance indicators, utilization trends, and advances in the field of vision care to enable us to continually meet industry standards or establish new industry benchmarks.

INTEGRATION OF SERVICES

Ensuring satisfaction to beneficiaries and plan sponsors is the hallmark of a Davis Vision Program. For more than a third of this century, Davis Vision has been creating innovative solutions to meet clients' vision care needs. Today, over thirty million people in all fifty states, Puerto Rico, Guam and Saipan enjoy the many benefits of a Davis Vision program and a commitment to quality care that is unsurpassed.

The Davis Vision program provides a comprehensive and integrated solution to vision care needs with the objectives of quality care, cost control, member satisfaction and close interactive relationships with clients and beneficiaries. These objectives are achieved through prevention-based processes at all levels, quality materials, qualified and credentialed practitioners, and administration and quality assurance systems that stand as the benchmark in the industry.

The organizational structure is an inverted triangle with senior management supporting all departments and self-managed associates. An organizational chart follows (Attachment "16") to illustrate this structure which allows for most client and beneficiary inquiries to be answered immediately by Davis Vision associates, who take a proprietary interest in our clients' needs and are empowered to make decisions without intervention, in most cases.

Davis Vision's self-managed approach to guaranteeing customer satisfaction results from a philosophy and culture that is embraced and supported by all associates throughout the organization ("100% Customer Delight") by adhering to a corporate culture of doing "Whatever It Takes!"

The Davis Vision program is unique in several ways. A primary emphasis is maintained on quality care and cost containment. The tremendous historical success of Davis Vision's programs exemplifies that the maintenance of strict quality standards and meaningful cost reduction methods can produce extraordinary satisfaction and verifiable value for plan beneficiaries and sponsoring organizations. Davis Vision stands out as the clear leader of vision care services.

ASSESSMENT

Recognizing and understanding the relationship between the perception of quality and the performance of processes to ensure quality, Davis Vision's leaders have been delegated the authority by the Board of Directors to coordinate, integrate and implement organization wide performance improvement activities. Davis Vision's leadership utilizes data information in the planning of:

- Goals – short and long term
- Services – new and revised
- Activities that will improve the satisfaction of all stakeholders.

Planning and designing begins with the analysis of data that is obtained from:

- Demographic composition of member population
- Utilization reports
- Claims encounters
- Provider encounters
- Medical record data
- Clinical guidelines
- Surveys - Member and Provider
- Results of audits
- Past performance levels
- Changes within the industry
- Regulatory or accrediting requirements
- Unexpected outcomes, such as a Sentinel Event
- Client requests
- Credentialing status reports

CONTINUOUS AUDITS

Davis Vision continually seeks opportunities for improvement, yet recognizes the importance of ongoing real-time assessment of service being offered to our members. Davis Vision monitors the following activities:

- Availability and access to care and services – GeoAccess reports (quarterly at a minimum).
- Entry, assessment and treatment processes – time frame from authorization date to utilization date.
- Preventive services – Health Fair participation, new contracts and renewals to include or expand benefit for preventative services such as VDT or safety eyewear and the Dilated Fundus Examination for Diabetics.

Resource Utilization

- Member and Provider satisfaction including ease of using benefit
- Member Grievances and Appeals
- Financial Audits – Quarterly
- Quality Control activities

Practitioner Integrity

- Reports are generated on a monthly basis advising of those practitioners to be re-credentialed within the next 120 days.

The Utilization Management Program describes other aspects of our continuous quality assurance activities.

DESIGN

The Quality Improvement Program is the process whereby activities are planned, designed, and measured to determine and assess performance. The analysis of outcome data allows Davis Vision to identify opportunities or challenges and implement action plans that would provide a meaningful improvement. Designing requires a proposal that includes:

- A clear rationale with objectives that are relevant
- A clear description of the identified population
- A clear statement of purpose. The methods to be used to gather the data will be determined with the activity objective
- Appropriate measures are identified

- Analysis of the current data utilizing benchmarks, including an analysis of the causes
- Strong targeted actions or goals that are achievable.

The selection of an improvement activity and how best to implement it will be based on the following considerations/criteria:

- The issue is important in terms of access, cost or quality. Davis Vision will focus on opportunities where improvement can be expected, maintained and sustained.
- The correct event was properly identified.
- Adequate research was completed to ensure that the action plan would have the desired impact. Utilizing research from databanks and/or publications will support the plan intervention and give a baseline of a measurable improvement.
- Adequate analysis of data and input from practitioners is utilized in the action plan.
- Activity is consistent with Davis Vision's Mission, Vision, Philosophy and Integrity Process
- Appropriate resources, financial and human, are available

Once again, recognizing the relationship between perception of quality and the performance of processes to ensure quality, Davis Vision's leadership has demonstrated their involvement and investment of time and resources (both financial and human) to achieve the cultural, strategic and technical changes required to maintain an organized Quality Improvement Program.

All Quality Improvement Committees meet on a regular basis and the program is evaluated annually.

DIMENSIONS OF PERFORMANCE

Davis Vision's goal for performance improvement activities is to initiate, implement and sustain the improvements over time. Davis Vision's leaders focus their improvement strategy on:

- Our mission
- Available resources – human and financial
- Network functions – component and independent practitioner
- Rights, Responsibilities and Ethics of member, provider, client and Davis Vision
- Education and Communication
- Health Maintenance
- Leadership – sound business practices
- Management of Information
- Current clinical knowledge
- Expectations of all stakeholders
- Contractual obligations

While we monitor outcomes data when planning an improvement activity, the value of the action must be evident. The opportunity for an improvement may be initiated by a variant in the

expectations, an occurrence of an adverse event, such as a Sentinel Event, or by feedback from our members, providers, clients or associates. The planning phase of the Quality Improvement activity must focus on the appropriate event that resulted in the outcome. Performance improvement activities, when planned, will verify that the improvement achieved was the direct result of the activity and thereby producing a value added improvement that will be maintained over time and will offer a significant change throughout the organization. Utilizing the "Plan – Do – Check – Act (PDCA)"[2] method for performance improvement, adopted from the 9-step method, planning the activity may include, when applicable:

PLAN (P)

Step One: Describing the Activity

A. The nature of the opportunity for improvement: This involves a clear statement of the activities objective and will include the following information:

- Identifying the affected population
- Database used to identify the population
- How was this identified as a meaningful activity
- Type of activity: care or service
- Aspect of service
- Quantifiable measure: Benchmark and the source used
- Performance goal or objective expressed in an appropriate numeric term
- Cost analysis, if applicable
- Time frame for implementation
- Champion of activity

B. Objectives and milestones: When the objective of each activity or task is determined, milestones must be established. Milestones can be expressed in time frames or in a numeric fashion, such as a proportion, ratio, or rate. To support goals or benchmarks analysis of the current data, utilizing the various databanks, must be stated as well as the methodology to be utilized in the proposed activity.

When establishing time frames for the action plan, it is recommended that a chart be drafted identifying persons involved (i.e., "who"), tasks (i.e., "what") and timeframes (i.e., "when") (see example).

[2] CQM Journal On-Line-Planning Projects and Tasks using the 9-steps.

What	Who	When
Gap Analysis of Information System		
Programming Requirements		
Implement the programming changes		

C. Alternative: Alternatives are established for each milestone in the event expectations are not achieved or an unforeseen obstacle is identified. When devising an action plan it is difficult to anticipate every possible cause and effect relationship. Establishing alternative plans will keep the activity focused on the outcomes and to ensure that the correct process for improvement was identified.

When establishing the milestones, objectives and alternatives an action plan will also be devised. The action plan will describe the various tasks that may be required to implement the plan. The action plan must indicate the time frame for each task and who has been assigned the responsibility.

D. Alternatives and Prioritizing: Improvement activities include expectations for improvement, the departments to be affected, and alternative steps for each phase of implementation. Comparing data will help detect the weakness and/or strength of the improvement. When the supporting documentation is completed it will be presented to the Quality Improvement Committee for review who will then present it to the Vice President of Professional Affairs and Quality Management for approval.

E. Approval: Davis Vision's organization-wide Quality Improvement Committee, under the supervision of the Vice President of Professional Affairs and Quality Management, reviews all performance improvement activities and will assess the value of each. Prioritizing activities is essential for success. Senior management, whose responsibilities include establishing short and long-term goals, evaluates all business issues and prioritizes the activities. The Committee will present the annual plan to senior management.

DO (D)

Step Two: Implementation and Monitoring

A. Deployment of improvement activity: In the planning phase, the activity was stated with the objectives and milestones described. In the next phase, DO, the detailed plan must be implemented and monitored. This phase is critical for the success of the activity. In the DO phase, not only is it important to monitor the outcome, but concurrently monitor who is doing what and when it is being done. It may be helpful when monitoring activities that require the participation of many associates from various locations to create a chart that will ease the workflow and to monitor the completion of each phase. The chart allows each associate to see who is responsible for each phase, thus allowing for a cohesive

workflow and guaranteeing the success of the activity.

Monitoring of performance outcomes is a critical phase of the activity. Data collection, frequency and intensity must equal the value of the activity. Insufficient data collection will limit the value of that data.

CHECK (C)

Step Three: Confirm the outcome data

A. Verify the outcome data. The data that was obtained during the planning phases will be compared to the existing data. If there is a variant in the outcome data the team will review the planning steps and make any changes necessary. Data will be collected for a significant period of time, up to six (6) months, or longer if indicated, to both maintain and sustain the improvement. If the performance improvement activity was for the design of a new service, at the point when the data is meeting expectations, Davis Vision will then formally adopt the process as part of its policy and procedures.

ACT (A)

Step Four: Standardize Process

A. Improvement: When data and goals have been confirmed the process must be standardized. When standardizing the process it is important to include all steps so that outcomes can consistently be achieved and maintained. When the process is new to the department or to Davis Vision's network, follow up must include:

1. New Process or Service: A written Policy and Procedure, including a time line for further monitoring, must be presented to the appropriate Quality Improvement Committee for review and Davis Vision's leadership for final approval.

2. Revised Process: Policy and Procedure containing the revisions must be presented to the appropriate Quality Improvement Committee; the department leader will give final approval.

3. Education of appropriate associates will be planned and scheduled.

DATA COLLECTION AND ANALYSIS

Davis Vision's Information System, CompuVision™, is the data collection tool utilized by Davis Vision for the continuous monitoring of the organization's performance, internally and externally. CompuVision™ has the capability to acquire, aggregate, assimilate, and disseminate on-line real-time accurate information. Davis Vision's leaders manage and utilize all information

generated by CompuVision™ to support the credibility and the soundness of short and long-term goals. The management and utilization of information to integrate processes, functions and services throughout the organization is essential for measuring Davis Vision's performance.

GOAL

Davis Vision's information system, CompuVision™, translates data into information allowing the leaders of Davis Vision to measure and assess their progress. Davis Vision's leaders utilize the information system data to provide overall understanding and purpose for responsiveness and effectiveness at all levels. Analysis of data captured by the system allows Davis Vision's leaders to provide a strong sense of purpose and vision for the organization. Data collection is an integral aspect of the Quality Improvement Program. This process is essential in the planning, design, and assessment of our performance. Davis Vision's monitoring of outcome data produces information that will allow the Quality Improvement Committees to:

- Establish a benchmark when none is available.
- Assess a current process.
- Identify areas where improvement is necessary, such as services that may be high volume or may be prone to challenges.
- Quantify that an objective has been achieved.
- Provide comparison and feedback.
- Yield information relevant to one or more aspects of performance.
- Detect a variant or a trend in a current performance.
- Plan and meet the needs and expectations of all customers both internally and externally.
- Plan, design, and assess objectives for future goals.

AUDITS

As part of the Quality Improvement Program, Davis Vision continually collects and analyzes information regarding the safety and quality of care. This information may include, but is not limited to:

- Access, availability and appropriateness of care and services
  - Entry, assessment and treatment processes
- Preventive services
- Utilization of benefits
- Satisfaction results:
  - Member
  - Provider
  - Client
- Provider Specific data
- Contractual obligations – performance guarantees

DATABANKS

Davis Vision's systems provide outcome data that is then analyzed to determine and prioritize what process or function to measure. Davis Vision's Quality Improvement outcome expectations are based on information obtained from:

- Satisfaction Surveys
  - Member
  - Provider
  - Client
- New guidelines or standards for clinical or business practices
- Changes within the industry
- Sentinel Events within the network or industry
- CompuVision™, Davis Vision's database program.
- Interactive Voice Response system (IVR)
- Claims encounters
- Provider encounters
- Medical record data
- Patient satisfaction or other surveys
- Industry standards
- HEDIS results
- Clinical guidelines
- Past performance levels
- JCAHO
- NCQA
- Other appropriate databases
- Performance Guarantees

Davis Vision's data collection processes allow ongoing evaluation and interpretation of performance. The assessment of the data collection allows us to determine:

- How consistent is our outcome?
- Were goals met?
- Were actions to improve performance successful?

DATA AGGREGATION AND ANALYSIS

Once an improvement activity has been identified the intent of the action plan will include:

1. Specific time frames and measurable objectives. For a meaningful improvement opportunity, the objective must be achievable.

2. The methodology to be utilized in the collection and analysis. This includes:
    - Method for determining size of the population affected by the activity
    - Inclusion criteria and /or parameters
    - Time period quantifiable measurement covers
    - The term of numerical measurement that will be used

Data collection is the basis for determining performance levels and the outcomes of processes. Processes are measured to determine and understand the causes of the results, both negative and positive. Outcomes are measured to determine and understand the results of processes. Data collection must be comprehensive, systematic and uniform. The scope and frequency of measurement will be of an intensity that will support and demonstrate that the improvement is the direct result of the activity. Collecting data measures the dimensions of performance relevant to specific functions, process and outcomes, thereby identifying areas for possible improvement or determining whether the implemented actions resulted in the improvement.

CALCULATING OUTCOME DATA

Numerical measurement of outcome data is preferred. Ratios, proportion, and rates are frequently used for these expressions, although they are commonly (and hereafter in this document) generically referred to as "rates". It is essential that appropriate calculations be preformed and reported with a consistency of methodology over time. Analysis and comparisons of rates within Davis Vision over time and across the industry require that all aspects of monitoring be equivalent.

Davis Vision Quality Improvement Activities indicators will, when appropriate, be represented in the following format:

- Numerators will indicate the frequency of the occurrence
- Denominator will indicate involved population.

ROOT CAUSE ANALYSIS

Our Quality Assurance program assumes responsibility for the initiation of a root cause analysis when an adverse event occurs, such as a Sentinel Event, as defined by Davis Vision. Following notification by a provider, associate, client, or member of an event an ad hoc Quality Assurance Committee will convene to initiate the review. Appropriate associates will be assigned to the

investigation team. These members may include the Chief Operating Officer, Vice President of Professional Affairs and Quality Management, Director of Professional Services, the Quality Assurance/Patient Advocate Department, the provider involved in the event and any appropriate office staff who may have also been involved in the event. Davis Vision will assign those associates most familiar with all aspects of the process under review.

A root cause analysis is the process whereby the contributory factors in the event are identified and analyzed in order to avert a reoccurrence. The contributory factors are those variations in performance in either clinical or organizational processes or systems. A root cause analysis can be conducted for any concern or opportunity for improvement. Situations that may benefit from a root cause analysis include, but are not limited to:

- Performance trends or patterns that fail to meet the expectations of Davis Vision
- Performance falls below the best professional and/or community practice standards
- When a sentinel event, as defined by Davis Vision, occurs
- Trends or patterns in member inquiries and/or complaints

A thorough root cause analysis will allow Davis Vision to identify the "proximate causes" and where best to focus changes that will improve performance and eliminate the risk of a reoccurrence. A thorough analysis includes, but is not limited to the following:

- A complete review and understanding of the event by the committee
- A thorough review of the organization's policies and procedures
- A step-by-step analysis of the processes or systems
- A review of all contributory factors that led up to the untoward outcome.
- Analysis of data so appropriate strategies to reduce risks are implemented
- Identifies potential improvements in the processes or systems
- Determines that no changes are warranted

Following investigation and identification of the causal factors, an action plan is developed. The action plan is comprised of the strategies that are to be implemented to reduce the risk of a reoccurrence. The action plan will include, but is not limited to:

- The identity of the associate responsible for implementing the plan
- The associate who will be responsible for overseeing the "day-to-day" performance
- The research material on which the improvements are based
- The time frames for reporting progress
- The database or system that will capture the data
- Methods that will be employed to measure the effectiveness and outcomes of the plan
- The strategies for re-education through out the organization
- Strategies for distributing material and/or other forms of information to those associates and/or providers who would most benefit.

A thorough and credible root cause analysis must focus on the variation of the process or systems, not on the individual. Although the individual may be considered a proximal cause of the event, it is generally the failure of the process and/or the built in safeguards that contribute to the event.

Davis Vision's objective while conducting a root cause analysis is to identify and change processes and/or systems that would improve our performance. The performance improvement activity will keep all associates of Davis Vision focused on the member's right to receive care or services that are safe.

LEADERSHIP

Introduction

Davis Vision operates under a corporate structure that utilizes the combined knowledge of three (3) individuals for day-to-day management and support. Those three (3) individuals comprise senior management as follows:

- Walter Froh, President/Chief Executive Officer
- Joseph Carlomusto, Chief Operating Officer
- Lawrence Gabel, Executive Vice President/Chief Financial Officer

The Quality Improvement Program begins with leadership and the organization's strategic plans. Senior management establishes the direction and creates patient-focused plans that have clear and visible value for the member and will achieve positive outcomes for all stakeholders.

Davis Vision's Quality Improvement Program specifically consists of:

- Quality Improvement Committee and Sub-Committees of:
    - Professional Peer Review Committee
    - Credentialing Committee
    - Patient Advocate Committee
    - Utilization Review Committee (comprised of Prior Approval and Concurrent Review Committee and Retrospective Review Committee)

Davis Vision's Vice President of Professional Affairs and Quality Management's functions include overseeing the evaluation and/or assessment of:

- Quality Improvement Committee activities to ensure consistency with the organization's Mission, Vision, Philosophy and Integrity Policy
- Davis Vision's policies and procedures on an annual basis.

The Chief Operating Officer has been delegated the responsibility to present the annual Quality Improvement Committee's activities and agenda to the Board of Directors of Davis Vision, Inc. and to provide formal approval each year, via signature, of each Davis Vision policy in place during the preceding year upon annual presentation by the Vice President of Professional Affairs and Quality Management.

QUALIFICATIONS OF COMMITTEE MEMBERS

The following positions or Committees must have at the minimum:

Vice President of Professional Affairs and Quality Management:	Licensed Optometrist
Director of Professional Services:	Licensed Optometrist
Professional Peer Review Committee:	At least one Licensed Optometrist
Patient Advocate Committee:	At least one Licensed Optometrist and/or Licensed Health Care Professional
Utilization Review Committee:	At least one Licensed Optometrist and/or Licensed Health Care Professional

REPORTING

Each Quality Improvement Committee will be under the direction of the Chairperson. For those committees not already chaired by the Vice President of Professional Affairs and Quality Management activities must be reported to the Vice President of Professional Affairs and Quality Management who, in turn, is charged with the responsibility of reporting directly to the Chief Operating Officer.

COMMITTEE STANDARDS

Davis Vision has established the following standards for each Committee:

- Minimum requirements for convening each Committee
- Minutes must be taken at each meeting and will be retained for a minimum of five (5) years.
- Minutes that identify members or providers will be kept confidential.
- Appropriate members must be present
- Annual plan must be submitted for approval
- Committee activities must be consistent with Davis Vision's Mission, Philosophy, Vision and Integrity Process
- Activities must be monitored and data available to support progress

- Changes in activities must be approved
- Committees must report to the Vice President of Professional Affairs and Quality Management when not already chaired by same.
- Significant challenges or a noted trend must be reported immediately, e.g., high incidence of complaints against a practitioner or increased abandonment rate.

QUALITY IMPROVEMENT COMMITTEE

Chairperson: Vice President of Professional Affairs and Quality Management

Members: Representative from the following departments:

Administrative Services	Human Resources
Benefit Administration	Independent Practitioner
Call Center	Information Systems
Client Relations	Member Representative
Credentialing Department	Professional Field consultants
Data Warehouse	Provider Recruitment
Finance	Regional Quality Assurance Representatives

Agenda: The Quality Improvement Committee establishes the threshold that should be obtained and maintained to ensure that the Davis Vision commitment to 100% satisfaction is achieved. Overall policy and strategy to achieve both short and long term goals shall be delineated. A review of the market, legal considerations, and issuance of governmental and other regulations, competitive forces, and new advances in technology will be considered.

Sub-Committees:

Professional Peer Review Committee, Patient Advocate Committee, Prior Approval and Concurrent Review Committee and Retrospective Review Committee

Responsibilities: Davis Vision's Quality Improvement Committee is responsible for:

- Reviewing policies and procedures
- Reviewing committee goals
- Reviewing the effectiveness and efficiency of daily departmental operations
- Reviewing interdepartmental relationships
- Suggesting possible solutions and delegating responsibility to appropriate associates for implementation
- Addressing any issues or concerns expressed by members or associates
- Establishing thresholds for reviews

Meetings: Quarterly

Reports to: Chief Operating Officer
Board of Directors, Davis Vision, Inc.

PROFESSIONAL PEER REVIEW COMMITTEE

Chairman: Vice President of Professional Affairs and Quality Management

Members: Director of Professional Services; Regional Quality Assurance Representatives; Consultant for Quality Assurance; Ad hoc network providers may also attend and support Committee meetings and activities.

Agenda: The role of the Professional Peer Review Committee is to ensure the integrity of our vision plans to clients, members and providers. The Professional Peer Review Committee is designed to assess, evaluate and monitor the quality, appropriateness and the cost of care rendered to Davis Vision patients. The Committee annually reviews the policies and procedures, including emerging technology, governing all aspects of patient care and clinical practice guidelines of providers.

All network providers are required to comply with all the policies, procedures and regulations as detailed in the Provider and Quality Improvement Manuals. Compliance is determined through a variety of utilization management strategies designed to ensure provider adherence.

Responsibilities: The Professional Peer Review Committee, which is comprised of licensed optometrists addresses all clinical issues. Committee responsibilities include, but are not limited to:

1. Credentialing, recredentialing and termination of all practitioners including the review and recommendation for changes in these processes. Criteria and recommendations for changes are approved by the Vice President of Professional Affairs and Quality Management.
2. Review and update the standards of care as delineated in the Provider and Quality Assurance Manuals.
3. Annual review of practice patterns and clinical practice guidelines to maintain current accepted practices.
4. Biennial analysis of inter-rater reliability study results of peer-reviewed medical records by the RQARs. These results reveal any aberrations and/or inconsistent ratings by any individual reviewer. The committee will adopt applicable educational training necessary for those showing an inconsistent rating tendency.
5. Review the relevant clinical practice guidelines promulgated by the American Optometric Association, the American Academy of Ophthalmology and other professional associations and groups.
6. Review emerging technology, clinical techniques and instrumentation applicable to the delivery of routine vision care. In reviewing these new technologies the committee will obtain published scientific evidence, when available and solicit feedback from network providers. When the committee determines that a new technology is widely available to most providers, relevant to routine vision care services and is cost-effective then it may recommend that the current applicable clinical guidelines be modified to incorporate this new technology.
7. Member Grievance and Appeal Process.
8. Review providers' compliance with Davis Vision's policies and procedures through site visits and record reviews, on and off-site.
9. Review the causes and outcomes of any sentinel events having occurred, if any.
10. Make recommendations for further consideration by the Quality Improvement Committee.
11. Will undertake studies specifically related to the development of standards to improve the health of members through the provision of quality eye care.
12. The Committee shall review the appropriateness of the benefits offered by Davis Vision and recommend standards and/or offer advice to ensure compliance by network providers.
13. The Committee shall review HEDIS indicators and recommend ways in which we can obtain and improve.

The role of the Professional Review Committee is to ensure the integrity of our vision plans to clients, members and providers. The Professional Review Committee is designed to assess, evaluate and monitor the quality, appropriateness and the cost of care rendered to Davis Vision patients. The Committee annually reviews the policies and procedures governing all aspects of patient care and clinical practice guidelines of providers.

All network providers are required to comply with all policies, procedures and regulations as detailed in the Provider and Quality Improvement Manuals. Compliance is determined through a variety of utilization management strategies designed to ensure provider adherence.

Meetings: At least annually with a quorum set at 3 members for any interim meeting.

Reports to: Chief Operating Officer

CREDENTIALING COMMITTEE

ROLE AND RESPONSIBILITY

The Credentialing Committee manages the entire credentialing/recredentialing process. This Committee regulates activities that determine original appointments and recertification of continuing privileges as well as the nature of disciplinary actions to be taken with individual providers. The Committee reviews the criteria, policies and procedures for credentialing and the formal application process annually. The Committee also determines a criterion for consideration of appointment to the panel. The Vice President of Professional Affairs and Quality Management, a licensed Optometrist, reviews and approves changes annually. Screening criteria for all review items (e.g., disciplinary actions, malpractice awards) are established by the Committee. The Credentialing Committee assists in validating the source verification of credentials submitted to Davis Vision as part of the credentialing process.

The Committee assures that the credentialing mechanism accurately verifies provider information such as licensure, malpractice history and existing privileges. Information that requires analysis/resolution by the Committee include disciplinary action by State licensing agencies, prior malpractice actions or judgments, current or past audits or sanctions from Medicare/Medicaid, any violation of the law if directly or indirectly related to an applicant's competence to practice. Thoughtful consideration of all such issues will be performed by the Committee and documented in the minutes. Information obtained from a structured review and site visit of the office is forwarded to the Credentialing Committee. In addition, utilization data, patient satisfaction results and all other pertinent information on each provider contained within the CompuVision™ credentialing software system is readily available to the Committee.

Staff members collect, validate and submit all documentation obtained during the verification process to the Credentialing Committee for review. The Committee reviews the data during their review to determine that the practitioner meets the criteria as a panel member for Davis Vision.

The Credentialing Committee evaluates the data obtained from the quality reviews, utilization management reports, provider profiles, member satisfaction surveys, and formal patient complaints during the recredentialing process. The Committee makes recommendations to continue, reduce, suspend or terminate privileges of participating providers. The Credentialing Committee also makes a determination when additional requirements are necessary for new programs or groups (e.g., DPA or TPA certification). Out-of-network providers are not credentialed.

COMMITTEE COMPOSITION - TERM AND VOTING RIGHTS

A three-member Committee makes recommendations on credentialing, recredentialing and termination decisions for all optometric practitioners. At least one of the three members shall include a practicing network provider from the community. Each member is accorded one vote and concession by a majority of the Committee members is necessary for all recommendations. A separate peer body of two members makes credentialing decisions on ophthalmologists. Each member serves a three-year term, which may be renewable.

The Committee reports to the Vice President of Professional Affairs and Quality Management or Director of Professional Services.

The Committee convenes as often as necessary to credential providers in a timely manner, but no less than twice a year. The Committee must have all recommendations for participation in the Davis Vision network approved by the Vice President of Professional Affairs and Quality Management or the Director of Professional Services.

The Committee maintains statistics on the number of new applications received annually, the number of practitioners credentialed, the number of providers recredentialed and the number of practitioners denied privileges. The Committee files an annual report of its actions and recommendations. An appeal mechanism for any adverse decision has been established. All appeals requests must be in writing.

To ensure timely, complete and accurate records, an appointed Committee member will record minutes for all Committee meetings in an approved standardized format. The minutes are to reflect recommendations, actions and participation by Committee members and must be approved by two members of the Committee. Recommendations are finalized, signed and dated by the Vice President of Professional Affairs and Quality Management or the Director of Professional Services. Minutes are kept in a secured file in the Credentialing/Quality Improvement office and shall be retained for a period of at least three (3) years.

PROVIDER APPEAL

A three-member review committee composed of at least one Regional Quality Assurance Representative also active in the provider network and participating panel providers who were not involved in the initial determination shall convene to review the merits and circumstances presented. Their recommendations are forwarded to the Vice President of Professional Affairs and Quality Management for final determination. There is no appeal of this decision.

Applications may be denied due to licensure limitations, sanctions, history of disciplinary actions, Medicaid or Medicare or other third party sanctions or exclusions, previous malpractice actions or other issues pertaining to one's professional qualifications. Providers are entitled to an explanation for the denial of their application.

INVESTIGATIVE REVIEW

An investigative review is initiated when issues arise as to quality, behavior, billing patterns or other concerns. This may include, but is not limited to, specific patient complaints, questionable billing practices, adverse patient satisfaction surveys, on-site visitations, record audits, or information received from outside agencies. Depending on the nature of the problem, the case will be reviewed by the Credentialing Committee, the Utilization Review Committee or the Quality Assurance Committee. Corrective action plans to address the deficiencies may be recommended. A follow-up review will help determine whether corrective action has been implemented. The Committee may recommend probation, suspension or termination. In all such cases the provider may appeal these decisions and proceed with the appeals process as described in Section IV.

PATIENT ADVOCATE COMMITTEE

Chairman: Vice President of Professional Affairs and Quality Management

Members:
Quality Assurance/Patient Advocate Department
Member Service Representatives
Licensed Professional Health Care Professional, when Applicable
Prior Approval Representatives
Regional Quality Assurance Representative
Member or member representative during appeal process, if requested

Agenda:
Reviewing Patient Satisfaction Surveys
Investigating concerns of members
Resolving concerns of members
Review consistency of appeal outcomes.
Documenting all communication with members, logging complaints and outcomes of concerns.

Responsibilities: The purpose of the Patient Advocate Committee is to meet and resolve patient-related issues, grievances and appeals, and to develop, review and revise, as necessary, Davis Vision's policy supporting member rights. The Committee is also charged with the review of all member communication including, but not limited to, the mechanism for disbursing information (e.g., postings on the Internet), Summary Plan Descriptions, etc. The Committee will also be available to any client wishing to develop and disburse member communication material.

Meetings: At least semiannually with a quorum set at two members for any interim meetings.

Reports to: Chief Operating Officer

PRIOR APPROVAL AND CONCURRENT REVIEW COMMITTEE

ROLE AND RESPONSIBILITY

Prior approvals are reviewed as the specialty-billing associate receives them and decisions are issued by telephone and in writing within two (2) business days of receipt of the necessary information. Prior Approval and Concurrent review may include:

- Collection of data about diagnosis, requested service, test results
- Comparison of information provided for medical necessity criteria
- Referral of case to providers peer for review if criteria are not met
- Receiving information from the provider supporting their request
- Peer review, Vice President of Professional Affairs and Quality Management, for determination of medical necessity
- Communication of review outcome
- Right of provider to appeal the decision

As part of the prior approval and concurrent review process Davis Vision will:

- Limit the information collected to the review being performed
- Promote timely decision
- Use explicit criteria to determine medical necessity
- Provide a mechanism to appeal the decision
- Utilize appropriate staff to make the determination

Davis Vision and the Quality Assurance department will maintain member and provider confidentiality during all reviews and documentation of outcomes. Outcomes will be reviewed quarterly.

Appeals and Grievance notification are per Davis Vision's Appeals Process or as required by state law.

UTILIZATION MANAGEMENT PROGRAM

Davis Vision provides policies, direction, support and education to client groups, providers and members to ensure the delivery of a high standard of cost-effective vision care services.

The purpose of the Utilization Management program is to promote competent, efficacious, and appropriate rendering of treatments and services to members that are medically necessary and are consistent with the Davis Vision guidelines. The appropriateness of the treatment or procedure is relevant to the member's vision condition and clinical needs given the current state of knowledge. Furthermore, the program is designed to assure the application of suitable procedures of peer reviews and audits that services are rendered only as and when medically necessary as determined in the exercise of reasonable limits of professional discretion. The Utilization Review Committee through the Professional Affairs Department of licensed health care professionals will review as to the medical necessity of treatment, procedures or services. Only licensed health care professionals, medical record technologists, or administrative personnel who have received appropriate training may obtain information from the health care provider for use in the utilization review process. Administrative personnel shall only perform intake screening, data collection and non-clinical review functions. Staff members who are not clinical peers may not render adverse determinations. The Utilization Review Committee will also review similar determinations requiring clinical judgment and expertise including quality of care issues of clients who desire this service. Additional aspects of the Committee are to make recommendations on standards of care, peer review, appeals, medically necessary criteria, and practice guidelines. Providers are required to follow the clinical guidelines of the American Optometric Association (AOA) and the American Academy of Ophthalmology (AAO). Utilization Management criteria shall not conflict with these practice guidelines.

In recognition of the fact that the healthcare industry and the laws and regulations that govern it are in a constant state of flux and therefore that our health care professionals must be aware of the ever changing legal and clinical issues in order to render sound opinions concerning appropriateness of treatments and procedures, Davis Vision has accordingly adopted a policy of formal training for our regional quality assurance representatives (RQARs).

The Board of Directors of Davis Vision, Inc. delegates the authority for the implementation of the Utilization Management Program to the Vice President of Professional Affairs and Quality Management who is a licensed optometrist and certified professional in utilization review (CPUR). Committee Members have experience in Peer Review, Quality Assurance Audits, Case Management and/or Utilization Review.

The Utilization Management program is to be evaluated and approved annually by the Vice President of Professional Affairs and Quality Management and the Quality Improvement Committee. A written program description shall include the scope of the program and the processes and information sources used to make the determinations of benefit coverage.

UTILIZATION REVIEW TRAINING PROGRAM

Davis Vision pursues training for its health care professionals through a nationally recognized certification organization which encompasses the fundamentals of the utilization review process, its evolution and current issues and trends, along with an explanation of the impact of legislation, regulation and accreditation on the process, and identifying strategies for developing an effective utilization review program.

Competency in utilization review principles is validated through a comprehensive Certified Professional Utilization Review (CPUR) certification exam designed to demonstrate an external, nationally recognized measure of knowledge and expertise and taken at the end of training. After passing the test, CPUR status is achieved and is valid for two (2) years. Certification can be renewed by re-taking the exam or through documentation of continuing education receipt relative to utilization review.

UTILIZATION REVIEW PROCESS

The keystone to effective management lies with an organization's utilization review activities. In order to contain costs and improve the quality of care, both the Utilization Review and Professional Peer Review Committees of the Utilization Management Program develop guidelines and establish criteria used for monitoring utilization and other associated quality issues.

Guidelines for prior authorizations and medical necessity services are developed and disseminated to the Prior Approval Department and other appropriate staff. Upon review of available information, including but not limited to, individual member circumstances and applicable contract language concerning benefits and/or exclusions, a member of the Professional Peer Review Committee makes a determination of medical necessity or appropriateness. This group is comprised of the Vice President of Professional Affairs and Quality Management, Director of Professional Services and Regional Quality Assurance Representatives (RQARs), all of who are licensed optometrists, and the Consultant for Quality Assurance. Ad hoc network providers and other non-professionals as appropriate will also attend and support Committee functions and meetings. Utilization Review agents may not accept anything of value to their employees, agents, or contractors based on: (i) either a percentage of the amount by which a claim is reduced for payment or the number of claims or the costs of services for which the person has denied authorization or payment; or (ii) any other method encouraging the rendering of an adverse determination. Oversight and review of procedures and statistics detailing the justification of any adverse decisions are noted in Committee minutes, along with copies of the required notifications, which will be retained for a minimum of five (5) years. Clinical practice guidelines developed by the American Optometric Association, American Academy of Ophthalmology as well as other scientific data may be referred to in making determinations. Davis Vision may also develop additional guidelines and standards in line with these associations.

All decisions of requests for prospective review (prior approval) for medical necessity of services will be made to the insured (or designee) and the insured's provider by telephone within two (2) business days of receipt of required information. The written decision will be mailed on the same day that the determination is made. Determination (and notice of determination to the insured and provider) involving continued or extended services or additional services for an enrollee undergoing continued services, shall be made within three (3) business days of receipt of the required information. The notification shall include the number of extended services approved, the new total of approved services, the date of onset and the next review date. Members may appeal adverse determinations according to the Davis Vision Grievance and Appeal Procedure. Failure to make a determination within the time periods prescribed herein shall be deemed to be an adverse determination subject to appeal.

Concurrent reviews for medical necessity may be conducted through our Member Service Representatives, Quality Assurance/Patient Advocate Department and/or the Quality Assurance Committee, as appropriate. All decisions will be issued to the insured and provider by telephone and in writing within one (1) business day of receipt of necessary information. Notification will include appeals rights and processes. Members may appeal adverse decisions according to the Davis Vision Grievance Procedure.

Retrospective Reviews are conducted when members challenge Davis Vision's decision to deny coverage or payment of a claim for rendered services. Retrospective review decisions that are denied, in whole or in part, by Davis Vision will be conveyed to the provider and member by telephone and in writing within thirty (30) days upon receipt of required information and will contain information regarding Davis Vision's appeal process.

Some state regulatory agencies dictate that the time frames and notification procedures provided above be adjusted to meet their particular guidelines. Davis Vision is observant of these time frames and procedures and will adjust its policies, to the best of its knowledge and ability, accordingly.

UTILIZATION REVIEW COMMITTEE

Chairman: Vice President of Professional Affairs and Quality Management

Members:
Director, of Professional Services
Regional Quality Assurance Representatives
Quality Assurance/Patient Advocate Associate
Quality Assurance Coordinator
Quality Assurance Consultant
Ad Hoc members as needed

Agenda: Committee responsibilities are delegated to the appropriate committee or sub-committee. Utilization Management Program responsibilities include, but are not limited to:

1. Analyzing provider profiles in conjunction with panel aggregate data.
2. Analyzing utilization data trends.
3. Analyzing cost centers.
4. Monitoring changing trends.
5. Reviewing all aspects of patient care which include, but is not limited to, credentialing, recredentialing and termination, appeal process, clinical practice guidelines, and reviews of practitioners' clinical practice.
6. Prior Approval, concurrent and retrospective reviews.
7. Quality Assurance/Patient Advocate Committee – Appeals and Grievances.

Sub Committees:
Professional Peer Review Committee
Patient Advocate Committee

Reports to: Chief Operating Officer

Meetings: Meetings are held biannually at a minimum.

SYSTEM MONITORING AND ANALYSIS

The utilization and quality performance of all providers is monitored on a continuous basis via the claims review process. Davis Vision's electronic claims management and adjudication system monitors provider behavior and utilization. A basic function of the system is to bring provider behavior into conformity with peer defined norms of quality and utilization. The system's statistical capacity compares individual provider profiles to aggregate information.

If a service has been specifically pre-authorized or approved for an insured by a Utilization Review Agent, a Utilization Review Agent shall not pursuant to retrospective review revise or modify the specific standards, criteria, or procedures used for the utilization review or procedures, treatments, and services delivered to the insured during the same course of treatment.

Only information that is necessary for prospective, concurrent or retrospective determination review may be collected. Routine requests of all patient records are not made. Only relevant sections of medical records needed to verify that services are medically necessary may be requested.

REPORTING AND ANALYSIS

During the performance of utilization functions, any quality assurance concerns or where patients are deemed at risk, a report is promptly sent to the Vice President of Professional Affairs and Quality Management.

1. Utilization review data is analyzed and recorded according to provider category.
2. Incidences of misuse by providers or patients will be referred for further action.

There are many strategies built into the Davis Vision Utilization Management system to control utilization and costs. The CompuVision™ system exclusively integrates critical components (provider network, ophthalmic laboratory, administration) of a vision benefit, allowing for pro- and retrospective review within a prevention-based and parameter-driven system. They include:

1. Profiling by CompuVision™ to monitor provider activity by procedure and diagnoses.
2. Follow-up of aberrant utilization or billing profiles.
3. Semi-annual provider "Report Cards" including dispensing rates and satisfaction results.

Under-utilization is also tracked through the Davis Vision system. Comparison of procedure (CPT) against diagnosis (ICD) across credentialed groups allows measurement of an entire specialist and sub-specialist group.

COMPLIANCE PROGRAM

The role of the Utilization Review Process is to ensure the integrity of our vision plans to clients, members and providers. The hallmark of the vision plan encompasses cost, quality and access to care. The Utilization Review Process is designed to assess, evaluate and monitor the quality, appropriateness and the cost of care rendered to Davis Vision patients. The Utilization Management Program annually reviews the policies and procedures governing all aspects of Davis Vision's benefit program and monitors the unitization of providers and patients.

All network providers are required to comply with all the policies, procedures and regulations as detailed in the Provider Manual. Compliance is determined through a variety of utilization management strategies designed to ensure provider adherence. The Davis Vision system controls under- and over-utilization using several approaches, as described below.

SCHEDULED ON-SITE OFFICE VISITS

One of the key elements of the Davis Vision Utilization Management Program is the on-site office review program. The scheduled office visits, conducted every twenty-four (24) months are for "high volume" providers who have rendered care to at least 300 of Davis Vision's members annually. The nature of these office visits alternate between Frame Collection audits by Professional Field Consultants (PFCs) and office and record reviews by Regional Quality Assurance Representatives (RQARs).

The PFC reviewer maintains the Davis Vision frame collection. They are also available for educating the providers and office staff regarding the Davis Vision website, placing exam claims and orders, understanding the various plans, benefits and obtaining prior authorizations.

When scheduling a site visit the PFC or RQAR will identify himself or herself as an agent of Davis Vision and will present photographic identification. Whenever possible, site visits will be scheduled at least one (1) business day in advance and need not disrupt office scheduling. The PFC or RQAR will, when requested, register with the appropriate contact person, if available, prior to requesting any clinical information or assistance from the health care provider.

The RQAR reviewer evaluates the physical facilities for overall appearance, safety and cleanliness, and additionally the office is inspected for equipment condition and maintenance. Office staff may be interviewed regarding protocols for scheduling, dispensing and compliance with Davis Vision's policies and procedures, which includes safety and infection control practices. The reviewer will examine a random sample of Davis Vision patient records (restricted to Plan members only). Confidentiality is maintained. The results of the visit are discussed with the provider and a formal review letter will follow.

These office visitations are an integral part of the Davis Vision Quality Improvement Program of which the Utilization Review is vital to quantify Davis Vision's performance.

In addition to being experienced in clinical practice, the reviewers have visited numerous network offices. They will be glad to discuss how other offices approach practice management and operational questions relating to participation with Davis Vision. Our reviewers are there to help you.

UNSCHEDULED OFFICE VISITS

Davis Vision retains the right to visit any provider's office at any time and without prior notice. Davis Vision has the right to conduct unscheduled office visits of providers' offices as a result of a member's concern and/or failure of the provider to implement or comply with a corrective action plan in response to a previous record audit. More frequent site visits may be scheduled as a result of findings from a prior site visit, record review or a review of the provider's billing profile.

During the on-site office review, scheduled and unscheduled, all aspects of the professional practice are reviewed including:

- Facility – patient safety and emergency preparedness
- Personnel - training and education
- Appointment availability
- Maintenance and use of proper equipment and instrumentation
- Patient's records
- Display of frame collection
- Compliance with participating provider agreement
- Compliance with Davis Vision's policies and procedures as described in the provider manual
- Infection control program

PATIENT RECORD REVIEW AUDIT

An integral part of its recredentialing process and Quality Improvement activities Davis Vision performs on and off-site review of records. On-site reviews are conducted by Regional Quality Improvement Representatives (RQARs). Off-site record reviews are performed by members of the Professional Peer Review Committee. Both of these groups operate are under the supervision of the Director of Professional Services.

The Provider Record Review tool, included in Attachment "12", is a weighed measurement of the practitioner's documentation on the patient record. All records shall include:

- Demographic information.
- Chief complaint and history of current concern including any systemic conditions that are relevant to the eye examination.

- Present status of current visual function including any recent changes in vision and the member's preferred corrective lenses (eyeglasses or contact lenses).
- Relevant past medical and surgical history.
- Allergic reactions to medications.
- Current medications.
- Relevant family ocular history.
- Social history: occupation, avocation, hobbies.
- Assessment and plan that is consistent with diagnosis.
- Patient education when medically indicated and/or follow-up.
- Referrals to specialists or primary care physician (PCP).
- Preventive screening if appropriate.
- Notation that patient was given appropriate care instructions or if patient refuses treatment he/she was made aware of the consequences.
- Notation if other alternative treatment was offered.
- Patient and/or designee signature.
- Examining provider's printed name and signature.
- Ocular examination – internal and external.
- Tonometry for adults.
- Distance refraction – objective and subjective.
- Treatment plans, disposition and patient education.
- Dilated fundus exam as professionally indicated.
- Accommodative evaluation.
- Appropriate visual acuities – distance and near.
- Ocular muscle evaluation.

The record review tool contains the elements of a routine eye examination. Each element has been assigned a point value that assists the RQARs to evaluate the practitioner's compliance with Davis Vision's policy on patient record documentation standards. Results are then collected, aggregated and analyzed by the Professional Affairs and Quality Improvement Committee. Providers are notified by mail of the audit outcome. Davis Vision informs providers that they have achieved a commendable score but their record keeping could be improved in a particular area; record keeping was incomplete and a corrective action plan is needed; record keeping practices had major deficiencies and a corrective action plan must be submitted within a designated time frame.

Davis Vision considers a provider compliant with Davis Vision's documentation standards when record keeping practices include the required member information as described in Section VIII, Examination and Documentation. Davis Vision considers a provider compliant when all examination information is entered and his or her score is 75% or more. The Professional Affairs Committee retains the right to require a corrective action plan if key elements are missing or incompletely documented in the medical record, even though the overall score is greater than 75%. Data from record reviews, on- or off-site, is considered during the recredentialing process.

Record review data obtained during an on- or off-site review is used during the recredentialing process. Providers must comply with the standards of documentation in accordance with Section IV of the applicable Participating Provider Agreement (Attachment "1").

QUALITY STUDIES

Davis Vision has built a quality component into its electronic claims management system. Using specific parameters and outliers, Davis Vision performs a range of quality and utilization studies.

The following utilization data elements are captured from individual patient files and can be reported on:

1. Eligibility and history
2. Authorization status
3. Laboratory orders processed
4. Status of orders
5. Number of days for completion
6. Payment status
7. Procedures performed
8. Diagnosis reported
9. Other information pertinent to member

The following utilization data elements are captured from provider files and tabulated on a quarterly basis:

1. Dispensing rates by clients and providers
2. Billing profile for specific services by providers
3. Procedures performed
4. Practice patterns
5. Non-plan frame utilization
6. Non-plan ophthalmic lenses utilization
7. Non-plan contact lenses utilization
8. Full services benefit utilization
9. "No charge" utilization
10. Patient satisfaction/"report card" data
11. Age-specific utilization data

PATIENT SATISFACTION

Davis Vision conducts a comprehensive patient satisfaction program. Its purposes are as follows:

1. Determine overall patient perception of the vision care plan.
2. Identify aspects of the program that patients would recommend to change.
3. Identify practitioners on the panel who are not providing courteous and high quality services to patients.
4. Identify elements of the system that could be causing delays in the provision of care.
5. Provide patients with the opportunity to offer positive feedback as well as to give critical comments about the program.
6. Offer patients the opportunity to ask questions regarding the program.
7. Provide feedback to the practitioners on their patients' responses to their care.
8. Provide feedback to the laboratory on the patients' responses to their services and materials.
9. Provide feedback to the program sponsor group on the assessment of the benefit by their constituents.

Patients' attitudes and perceptions are the fundamental component of quality improvement. This is why Davis Vision members have the right to access and express their opinions and concerns. Patients obtaining services have the opportunity to complete a patient satisfaction survey (Attachment "17") to express their views concerning the quality of services rendered. This survey instrument is designed to elicit the patient's opinion on access to care, the professional staff's treatment of the patient and their satisfaction with the examination and prescriptive eyewear. Each survey response is carefully reviewed with follow-up action promptly taken, where necessary. We are proud to constantly achieve an initial satisfaction rate of over 98%. Those surveyed who indicate less than total satisfaction are individually contacted to ensure 100% satisfaction.

When responses are received, they are first recorded for statistical analysis. All reports containing entries in the "comments" section are reviewed and researched by the Quality Assurance/Patient Advocate Department and the comments may be distributed to the respective practitioners and shared with the client as appropriate. Panel doctors for whom at least ten (10) completed surveys are received will semiannually receive comparative statistics for their office(Attachment "17"). When indicated, providers are asked to respond to concerns raised by members. The results of these surveys may be shared with the Regional Quality Assurance Representative, the Quality Assurance and Utilization Review Committees and client's representatives. Satisfaction surveys are used as part of the recredentialing process.

FRAME COLLECTION AND MATERIAL UTILIZATION AUDIT

Once a practitioner becomes a network provider they may, or may not, receive possession of a Davis Vision Frame Tower depending on certain circumstances in place at the time and mutual agreement of the provider and Davis Vision. Such possession is considered to be a bailment because the provider takes possession of the Tower but not title or ownership. Title remains with Davis Vision and allows Davis Vision to take control and re-possession of the Tower at any time.

The Frame Tower is a display vehicle for the selection of approved spectacle frames that is to be featured in the provider's office, accessible to Davis Vision members and maintained in good condition. The provider is responsible for the cost of any missing frames and will be required to reimburse Davis Vision for any missing or otherwise unaccountable frames.

INVENTORY OF PLAN FRAMES

Davis Vision's annual frame audit is conducted under the supervision of the Professional Field Consultant Department. Davis Vision's associates with the assistance of RGIS, an inventory specialist organization, visit all provider offices that have a Davis Vision Frame Tower. All frames that are currently available in a provider's office are manually counted or scanned. This information is then compared to frame ordering and shipment invoices and discrepancies are discussed with the provider. Per the Participating Provider Agreement, providers are responsible for these discrepancies.

The Inventory of Plan frames by Professional Field Consultants may include:

1. Display Condition
2. Removal of Discontinued Frames
3. Replacement of Missing Frames
4. Physical Structure - Office Condition
5. Staff Training and Education

MATERIAL UTILIZATION AUDITS

Material Utilization Audits is the collection, aggregation and analysis of data that identifies the ordering patterns of providers. The reports includes information such as:

1. The ordering of Plan Frames
2. The ordering of Non-Plan Frames
3. The ordering of lenses

Davis Vision analyzes these reports to determine if providers ordering trends are consistent with other providers in the area.

Through CompuVision™, our claims processing software, Davis Vision monitors each panel office for provision of eye examinations, frames and lenses to assure that appropriate utilization standards are maintained. Individual practitioners are compared to the utilization patterns of the entire provider panel. Tabulated data on billing codes and claims are analyzed with respect to full and partial services received by members and dependents.

A Regional Quality Assurance Representative investigates unusual utilization trends when reports identify aberrant profiles; the practitioner is contacted and afforded the opportunity to correct any inappropriate practices or behavior. Continued aberrant practices may result in a review by the Professional Peer Review Committee.

PROVIDER PARTICIPATION

Davis Vision's Annual Quality Improvement Activities are available for comment to all participating providers on Davis Vision's web site. Providers may log on to **www.davisvision.com** to view and comment on the current quality initiatives. Davis Vision's Quality Improvement Committee meets quarterly. Providers who would like to attend a meeting are invited to call 1 (800) 328-4728, Department of Professional Affairs to reserve a seat.

CLINICAL PRACTICE GUIDELINES

Davis Vision has adopted the Clinical Practice Guidelines of the American Optometric Association (AOA) and the American Academy of Ophthalmology (AAO). Providers have Internet access to these guidelines by logging on to Davis Vision's web site at **www.davisvision.com**. Hard copies of these guidelines are available by contacting the above associations directly.

2006
QUALITY IMPROVEMENT
GOALS AND INITIATIVES

Davis Vision's Quality Improvement Program is based on the Malcolm Baldrige Health Care Criteria for Performance Excellence. Recognizing the relationship between perception of quality and the performance of processes to ensure quality, Davis Vision has assumed the responsibilities to coordinate, integrate, and implement organization wide performance improvement activities. Davis Vision's leadership is evident throughout the organization by the leaders' involvement and investment of time and resources (financial and human) to achieve the cultural, strategic, and technical changes required managing a quality environment. Under the leadership of the Vice President of Professional Affairs and Quality Management, Davis Vision has developed a Quality Improvement Program designed to evaluate the services, treatment and products provided to our members.

The dimensions of the Quality Improvement Program afford Davis Vision the ability to continuously collect, aggregate and analyze data on specific eye care conditions found within its population in order to evaluate the effectiveness of our performance. The intent of the Quality Improvement Program is to achieve significant and meaningful improvements in the care, services and support processes offered by Davis Vision. The program design allows for the collaborative effort between leaders, associates, independent practitioners, components and members to assess our performance and determine our strengths. Quality Improvement at Davis Vision is defined and measured by determining the level of member satisfaction and that the member's outcome was positive.

As part of our Quality Improvement Program, Davis Vision tracks activities that demonstrate meaningful improvement in patient care as a direct result of Davis Vision's implemented measures. These meaningful improvements and interventions will improve the outcomes of the services offered to current and future members of Davis Vision. The Quality Improvement Program is the process whereby activities are planned, designed, measured, and assessed to determine the impact on clinical outcomes and network performance.

Davis Vision has identified numerous activities that will improve performance, internally and externally, thereby improving member satisfaction. Davis Vision shall collect, aggregate and analyze data on specific eye care conditions found within its population. Quantitative measures have been identified that when analyzed will provide Davis Vision the opportunity to assess and evaluate the outcomes and performance of clinical guidelines.

Davis Vision's Quality Improvement Committee has identified meaningful activities that offer an opportunity to improve member service by decreasing the turnaround time in providing the member with their eyewear and provide Davis Vision with a financial savings.

Davis Vision's Quality Improvement Plan for 2006 includes the following activities:

Activity Name:	Viva/Davis Vision Provider Partnership Program
Affected Population:	Davis Vision participating providers.
Goal:	Increase provider satisfaction and web ordering while stimulating Viva frames sales among participating providers.
Measure:	Track number of providers enrolled at each participation level as well as the number and percentage of providers attaining maximum incentive at each participation level and total incentive amount paid.
Time Period:	February 1, 2006 through December 31, 2006 Ongoing reporting

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Activity Name:	Develop Universal Frames Data Catalogue within CompuVision™ Order Entry System
Affected Population:	Davis Vision participating providers and staff.
Goal:	Enhanced data collection and reporting of all frame usage to better identify industry trends.
Measure:	Successful implementation of the catalogue. Development of baseline measures for subsequent quality improvement activities.
Time Period:	January 1, 2006 through October 31, 2006 Ongoing reporting

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Activity Name:	Develop Universal Contact Lens Catalogue within CompuVision™ Order Entry System
Affected Population:	Davis Vision participating providers and staff.
Goal:	Enhanced data collection and reporting of all contact lens usage to better identify industry trends and improved adherence to formulary.
Measure:	Successful implementation of the catalogue. Development of baseline measures for subsequent quality improvement activities.
Time Period:	January 1, 2006 through October 31, 2006 Ongoing reporting

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Activity Name:	Enhance Fashion Frame Collection
Affected Population:	Davis Vision members enrolled in entry-level material benefit programs and medical assistance plans.
Goal:	Expand and enhance style and selection of frames in Fashion level collection to better service accounts/members purchasing from within entry level plans.
Measure:	Expansion of the Fashion Collection to represent thirty percent (30%) of the total frame collection.
Time Period:	January 1, 2006 through December 31, 2006 Ongoing reporting

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Activity Name:	Introduce Viva/Davis Vision Private Brands to the Tower Collection
Affected Population:	All Davis Vision members and participating (dispensing) providers.
Goal:	To improve upon the quality of private label frame offerings and increase quantity and visibility of Viva product within the Tower Collection.
Measure:	Introduction of initial private label brands within the Fashion and Designer frame collections.
Time frame:	January 1, 2006 through September 30, 2006 Ongoing reporting

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Activity Name:	Implement Claims Imaging System Utilizing MACESS
Affected Population:	Davis Vision claims processors, mailroom clerks and quality review staff.
Goal:	Increased ability to manage and report claims workflows and performance results while decreasing administrative costs.
Measure:	Successful implementation of the claims imaging system resulting in elimination of storage of paper claims and maintenance of automated inventory of all in-process claims with no increase to claims cost.
Time Period:	January 1, 2006 through October 31, 2006 Ongoing reporting

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Activity Name:	Implement Utilization Review (UR)/Utilization Management (UM) Workflow Management System Utilizing MACESS
Affected Population:	Davis Vision quality assurance (QA) and utilization management (UM) associates as well as members and providers requesting prior approval for medically necessary or other exceptional services and clients that delegate and conduct oversight of UM functions.
Goal:	Provide framework for consistent, timely processing of UR/UM letters, denials, appeals and related activities as required.
Measure:	Successful implementation of the UR/UM system with automation of communications with at least ninety-eight percent (98%) compliance with regulatory protocols.
Time Frame:	January 1, 2006 through October 31, 2006 Ongoing reporting

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Activity Name:	Convert Strategic Network Providers to Electronic Claims Submission and Processing
Affected Population:	Davis Vision claims processors and strategic network providers' staff.
Goal:	To increase claims processing accuracy and reduce turnaround time and administrative costs.
Measure:	Track number and percentage of claims submitted electronically. Increase the percentage of claims submitted electronically by strategic network providers to eighty percent (80%).
Time Period:	January 1, 2006 through June 30, 2006 Ongoing reporting.

Activity Name:	Revise Group Implementation Process
Affected Population:	Davis Vision operational and administrative associates involved in the set-up and implementation of contracted client groups.

Goal:	To improve accuracy and timeliness of new group set-up within CompuVision™.
Measure:	Develop and implement new process for set-up on new client groups to achieve ninety percent (90%) of new group implementations complete at least ten (10) days prior to the new group effective date (subject to receipt of all necessary client generated documentation).
Time Frame:	January 1, 2006 through August 31, 2006 Ongoing reporting.

Activity Name:	Design and Implement Aspect Workforce Management Program
Affected Population:	All Davis Vision call center associates and management.
Goal:	Improve labor optimization and coordination of associate schedules in support of expanded operating hours and seven (7) day a week operations.
Measure:	Reduction in overtime within the Call Center by five percent (5%) in the second-half of 2006 in comparison to the same period of time in 2005.
Time Frame:	January 1, 2006 through June 30, 2006 Ongoing reporting.

Activity Name:	NCQA Re-Certification in Credentialing
Affected Population:	All Davis Vision clients, members, providers and associates.
Goal:	To maintain certification to enhance client confidence and encourage delegation of credentialing.
Measure:	Attainment of certificate of accreditation.
Time Frame:	January 1, 2006 through July 31, 2006 Ongoing reporting.

Activity Name:	URAC Healthcare Website Accreditation
Affected Population:	All Davis Vision clients, members, providers and associates.
Goal:	To attain accreditation to achieve distinction within the marketplace.
Measure:	Attainment of certificate of accreditation.
Time Frame:	January 1, 2006 through December 31, 2006 (pending scheduling by URAC) Ongoing reporting.

Activity Name:	Redesign Patient and Provider Satisfaction Survey Tools
Affected Population:	All Davis Vision members and participating providers as well as quality assurance staff.
Goal:	Enhance validity and reliability of satisfaction measures.
Measure:	Establish baselines for patient and provider satisfaction levels for ongoing comparison and analysis.
Time Frame:	January 1, 2006 through September 30, 2006 Ongoing reporting.

Activity Name:	Develop Diabetic Outreach Data Mart
Affected Population:	Davis Vision members who have been identified and flagged as having been diagnosed with diabetes. Davis Vision managed care organization (MCO) clients who have been able to identify diabetic members within their covered populations.
Goal:	To enhance tracking, reporting and analysis of diabetic utilization to support enhanced wellness for the diabetic population and to provide information to study trends, identify the efficacy of interventions and the impact on HEDIS scoring.
Measure:	Utilization among diabetic population compared to the general population. A comparison of diabetic utilization among groups and benefit designs. Establish baseline measures for ongoing quality improvement initiatives.
Time Frame:	January 1, 2006 through December 31, 2006 Ongoing reporting.

Activity Name:	Consolidate Laboratories and Services
Affected Population:	Davis Vision members, providers and clients.
Goal:	To improve laboratory efficiency while reducing operating expenses.
Measure:	Average turnaround time and average cost per job per laboratory.
Time Frame:	January 1, 2006 through December 31, 2006 Ongoing reporting.

Activity Name:	Establish Anti-Reflective (AR) Coating Facility in Plainview Laboratory
Affected Population:	Davis Vision clients, members, providers and associates.
Goal:	To reduce cost and turnaround time to produce high quality AR product.
Measure:	The number of AR orders processed and the number and percent of AR returns pre- and post-implementation of internal capability. Average turnaround time on AR orders pre- and post-implementation of internal capability.
Time Frame:	January 1, 2006 through September 30, 2006 Ongoing reporting.

ATTACHMENTS

DAVIS VISION, INC.
PARTICIPATING PROVIDER AGREEMENT

This **PARTICIPATING PROVIDER AGREEMENT** (hereinafter "Agreement") is entered into by and between **DAVIS VISION, INC.**, having its principal place of business located at 159 Express Street, Plainview, New York 11803 ("**DAVIS"**), and _____

[Insert PROVIDER's full legal entity name]

having his/her/its principal place of business located at _____

_____("**PROVIDER"**).

[Insert PROVIDER's complete address]

RECITALS

WHEREAS, **DAVIS** has entered into or intends to enter into agreements (hereinafter "Plan Contract(s)") with health maintenance organizations and other purchasers of vision care services (hereinafter "Plan(s)"); and

WHEREAS, **DAVIS** has established or shall establish a network of participating vision care providers (hereinafter "Network") for the provision of or to arrange for the provision of vision care services to individuals (hereinafter "Members") who are enrolled as Members of such Plans; and

WHEREAS, the parties desire to enter into this Agreement whereby **PROVIDER** agrees (upon satisfying all Network participation criteria) to provide certain vision care services (hereinafter "Covered Services") on behalf of **DAVIS** to Members of Plans under Plan Contract(s) with **DAVIS**.*****

NOW, THEREFORE, in consideration of the mutual covenants and promises contained herein, and intending to be bound hereby, the parties agree as follows:

I
PREAMBLE AND RECITALS

.1 The preamble and recitals set forth above are hereby incorporated into and made a part of this Agreement.

II
DEFINITIONS

.1 "**Centers for Medicare and Medicaid Services**" ("CMS") means the division of the United States Department of Health and Human Services, formerly know as the Health Care Financing Administration (HFCA) or any successor agency.

.2 "**Clean Claim**" means a claim for payment for Covered Services which contains the following information: (a) a valid authorization number, referencing Member and Member information; (b) a valid, **DAVIS-**assigned **PROVIDER** number; (c) the date of service; (d) the primary diagnosis code; (e) an indication as to whether or not dilation was performed; (f) a description of services provided (i.e. examination, materials, etc.); and (g) all necessary prescription eyewear order information (if applicable). Any claim that does not have all of the information herein set forth may be pended or denied until all information is received from the **PROVIDER** and/or Member.

.3 "**Copayment**" **or "Deductible**" means those charges for vision care services, which shall be collected directly by **PROVIDER** from Member as payment, in addition to the fees paid to **PROVIDER** by **DAVIS**, in accordance with the Member's benefit program.

.4 "**Covered Services**" means a complete and routine eye examination including, but not limited to, visual acuities, internal and external examination, (including dilation where professionally indicated,) refraction, binocular function testing, tonometry, neurological integrity, biomicroscopy, keratometry, diagnosis and treatment plan and when authorized by state law and covered by a Plan, medical eye care, diagnosis, treatment and eye care management services, and ordering and dispensing plan eyeglasses from a **DAVIS** laboratory, when applicable.

.5 "**Generally Accepted Standards of Medical Practice**" means standards that are based upon: credible scientific evidence published in peer-reviewed medical literature and generally recognized by the relevant medical community; physician and health care provider specialty society recommendations; the views of physicians and health care providers practicing in relevant clinical areas and any other relevant factor as determined by statute(s) and/or regulation(s).

.6 "**Managed Care Organization**" (MCO) means an entity that has or is seeking to qualify for a comprehensive risk contract and that is: (1) a Federally qualified HMO that meets the advance directives requirements of 42 CFR 489.100-104; or (2) any public or private entity that meets the advance directives requirements and is determined to also meet the following conditions: a) makes the services it provides to its enrollees as accessible (in terms of timeliness, amount, duration, and scope) as those services are accessible to other recipients within the area served by the entity, and b) meets the solvency standards of 42 CFR 438.116.

.7 "**Medical Assistance Program**" ("MAP") means the joint Federal and State program, administered by the State and the Centers for Medicare and Medicaid Services (and its successors or assigns), which provides medical assistance to low income persons pursuant to Title 42 of the United States Code, Chapter 7 of the Social Security Act, Subchapter XIX Grants to States for Medical Assistance Programs, Section 1396 et seq, as amended from time to time, or any successor program(s) thereto regardless of the name(s) thereof.

.8 "**Medical Necessity" / "Medically Necessary Services"** With respect to the Medicaid program, "Medical Necessity" or "Medically Necessary Services" are those services or supplies necessary to prevent, diagnose, correct, prevent the worsening of, alleviate, ameliorate, or cure a physical or mental illness or condition; to maintain health; to prevent the onset of an illness, condition, or disability; to prevent or treat a condition that endangers life or causes suffering or pain or results in illness or infirmity; to prevent the deterioration of a condition; to promote the development or maintenance of maximal functioning capacity in performing daily activities, taking into account both the functional capacity of the individual and those functional capacities that are appropriate for individuals of the same age; to prevent or treat a condition that threatens to cause or aggravate a handicap or cause physical deformity or malfunction, and there is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the enrollee. The services provided, as well as the type of provider and setting, must be reflective of the level of services that can be safely provided, must be consistent with the diagnosis of the condition and appropriate to the specific medical needs of the enrollee and not solely for the convenience of the enrollee or provider of service and in accordance with standards of good medical practice and generally recognized by the medical scientific community as effective. A course of treatment may include mere observation or where appropriate no treatment at all. Experimental services or services generally regarded by the medical profession as unacceptable treatment are not Medically Necessary Services for purposes of this Agreement.

.9 **"Medical Necessity" / "Medically Necessary" / "Medically Appropriate"** With respect to the Medicare and/or Medicare Advantage program, in order for services provided to be deemed Medically Necessary or Medically Appropriate, Covered Services must: (1) be recommended by a **PROVIDER** who is treating the Member and practicing within the scope of her/his license and (2) satisfy each and every one of the following criteria:

(a) The Covered Service is required in order to diagnose or treat the Member's medical condition (the convenience of the Member, the Member's family or the Participating Provider is not a factor to be considered in this determination); and

(b) The Covered Service is safe and effective: (i.e. the Covered Service must)
(i) be appropriate within generally accepted standards of practice;
(ii) be efficacious, as demonstrated by scientifically supported evidence;
(iii) be consistent with the symptoms or diagnosis and treatment of the Member's medical condition; and
(iv) the reasonably anticipated benefits of the Covered Service must outweigh the reasonably anticipated risks; and

(c) The Covered Service is the least costly alternative course of diagnosis or treatment that is adequate for the Member's medical condition; factors to be considered include, but are not limited, to whether the Covered Service can be safely provided for the same or lesser cost in a medically appropriate alternative setting; and

(d) The Covered Service, or the specific use thereof, for which coverage is requested is not experimental or investigational. A service or the specific use of a service is investigational or experimental if there is not adequate, empirically-based, objective, clinical scientific evidence that it is safe and effective. This standard is not met by (i) a Participating Provider's subjective medical opinion as to the safety or efficacy of a service or specific use or (ii) a reasonable medical or clinical hypothesis based on an extrapolation from use in another setting or from use in diagnosing or treating a different condition. Use of a drug or biological product that has not received FDA approval is experimental. Off-label use of a drug or biological product that has received FDA approval is experimental unless such off-label use is shown to be widespread and generally accepted in the medical community as an effective treatment in the setting and condition for which coverage is requested.

.10 "**Medically Appropriate/Medical Necessity"**; With respect to Plans other than Medicare, Medicare Advantage and Medicaid, the term "Medically Appropriate" means or describes a vision care service(s) or treatment(s)that a **PROVIDER** hereunder, exercising **PROVIDER**'s prudent, clinical judgment would provide to a Member for the purpose of evaluating, diagnosing or treating an illness, injury, disease, or its symptoms and that is in accordance with the "Generally Accepted Standards of Medical Practice"; and is clinically appropriate in terms of type, frequency, extent site and duration; and is considered effective for the Member's illness, injury or disease; and is not primarily for the convenience of the Member or the **PROVIDER**; and is not more costly than an alternative service or sequence of services that are at least as likely to produce equivalent therapeutic and/or diagnostic results as to the Member's illness, injury, or disease.

.11 "**Medicare**" means the Federal program providing medical assistance to aged and disabled persons pursuant to Title 42 of the United States Code, Chapter 7 of the Social Security Act, Subchapter XVIII Health Insurance for Aged and Disabled, Section 1395 et seq, as amended from time to time, or any successor program(s) thereto regardless of the name(s) thereof.

.12 "**Medicare Advantage Member**" means a Member who is enrolled in and covered under a Medicare Advantage Program.

.13 "**Medicare Advantage Program**" means a product established by Plan pursuant to a contract with CMS which complies with all applicable requirements of Part C of Title 42 of United States Code, Chapter 7 of the Social Security Act, Subchapter XVIII Health Insurance for Aged and Disabled, Section 1395 et seq, as amended from time to time, and which is available to individuals entitled to and enrolled in Medicare or any successor program(s) thereto regardless of the name(s) thereof.

.14 "**Member**" means an individual and the eligible dependents of such an individual who are enrolled in or who have entered into contract with or on whose behalf a contract has been entered into with Plan(s), for the provision of Covered Services. Eligible dependents of Members typically include spouses, minor children, and adult children who are full-time students.

.15 "**Network**" means the arrangement of Participating Providers established to service eligible Members and eligible dependents covered by Plan(s).

.16 **"Non-Covered Services**" means those vision care services which are not Covered Services under Plan Contract(s).

.17 "**Participating Provider**" means a licensed health facility which has entered into or a licensed health professional who has entered into an agreement with **DAVIS** to provide Medically Appropriate Covered Services to Members pursuant to the Plan Contract(s) between **DAVIS** and Plan(s) and those employed and/or affiliated, independent, or subcontracted optometrists or ophthalmologists who have entered into agreements with **PROVIDER**, who have been identified to **DAVIS**, have satisfied Network participation criteria, and who will provide Medically Appropriate Covered Services to Members pursuant to the Plan Contract(s) between **DAVIS** and Plan(s). All obligations hereunder that are applicable to **PROVIDER** are and shall be deemed to be applicable as to Participating Provider(s) hereunder.

.18 "**Plans**" means a health maintenance organization, corporation, trust fund, municipality, or other purchaser of vision care services that has entered into a Plan Contract with **DAVIS**.

.19 "**Plan Contracts**" means the agreements between **DAVIS** and Plans to provide for or to arrange for the provision of vision care services to individuals enrolled as Members of such Plans.

.20 "**Provider Manual**" means the **DAVIS** Vision Care Plan Provider Manual, as amended from time to time by **DAVIS**.

.21 "**State**" means the State in which **PROVIDER**'s practice is located or the State in which the **PROVIDER** renders services to a Member.

.22 "**United States Code of Federal Regulations**" (hereinafter "CFR") means the codification of the general and permanent rules and regulations published in the Federal Register by the executive department and agencies of the Federal government.

.23 "**United States Department of Health and Human Services**" (hereinafter "DHHS") means the executive department of the Federal government which provides oversight to the Centers for Medicare and Medicaid Services (CMS).

III
SERVICES TO BE PERFORMED BY THE PROVIDER

.1 **Frame Collection**. As a bailment, **and if applicable**, **PROVIDER** shall maintain the selection of Plan approved frames in accordance with the Provider Manual and as set forth herein:

(a) **PROVIDER** agrees that the frame collection will be shown to all Members receiving eyeglasses under the Plan.
(b) **PROVIDER** agrees that the frame collection shall be openly displayed in an area accessible to all Members.
(c) **PROVIDER** shall maintain the frame collection in the exact condition in which it was delivered less any normal deterioration.
(d) **PROVIDER** shall not permanently remove any frames from the display. **PROVIDER** shall not remove any advertising materials from the display.
(e) The cost of the frame collection and display is assumed by **DAVIS** and remains the property of **DAVIS**. **DAVIS** retains the right to take possession of the frame collection when **PROVIDER** ceases to participate with the Plan and at any other time upon reasonable notice. **PROVIDER** assumes full responsibility for the cost of any missing frames and will be required to reimburse **DAVIS** for missing and unaccounted for frames.
(f) At any time and upon reasonable notice **DAVIS** shall have the right to alter the advertising materials displayed as well as any frame(s) contained in the collection.
(g) Should the display and/or frame(s) contained in the collection be damaged due to acts of God, acts of terrorism, war, riots, earthquake, floods, or fire, **PROVIDER** shall assume the full cost of the display and/or the frame collection and will be required to reimburse **DAVIS** its/their fair market value.

.2 **Open Clinical Dialogue**. Nothing contained herein shall preclude **PROVIDER** from engaging in open clinical dialogue with Members, including but not limited to the discussion of all possible and/or applicable treatments, whether such treatments are Covered Services under the applicable **DAVIS** benefit plan designs.

.3 **Services**. **PROVIDER** shall provide all Medically Appropriate Covered Services to Members within the scope of his/her/its license, and shall manage, coordinate and monitor all such care rendered to each such Member to ensure that it is cost-effective and Medically Appropriate. **PROVIDER** agrees and acknowledges that Covered Services hereunder shall be governed by and construed in accordance with all laws, regulations, and contractual obligations of the MCO.

.4 **Scope of Practice**. The parties hereto agree and acknowledge that nothing contained in this Agreement shall be construed as a gag clause limiting or prohibiting **PROVIDER** and/or Participating Providers from acting within his/her/its lawful scope of practice, or from advising or advocating on behalf of a current, prospective, or former patient or Member (or from advising a person designated by a current, prospective, or former patient or Member who is acting on patient/Member's behalf) with regard to the following:

.4.1 The Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;

.4.2 Any information the Member needs in order to decide among all relevant treatment options;

.4.3 The risks, benefits, and consequences of treatment versus non-treatment;

.4.4 The Member's right to participate in decisions regarding his or her health care, including the right to refuse treatment and to express preferences about future treatment decisions;

.4.5 Information or opinions regarding the terms, requirements or services of the health care benefit plan as they relate to the medical needs of the patient; and

.4.6 The termination of **PROVIDER**'s agreement with the MCO or the fact that the **PROVIDER** will otherwise no longer provide vision care services under the **DAVIS** Plan Contract(s) with MCO.

.5 **Treatment Records**. **PROVIDER** shall (1) establish and maintain a treatment record consistent in form and content with generally accepted standards and the requirements of **DAVIS** and Plan(s); and (2) promptly provide **DAVIS** and Plan(s) with copies of treatment records when requested; and (3) keep treatment records confidential.

IV
COMPENSATION

.1 **Compensation**. **DAVIS** shall pay **PROVIDER** the compensation amounts that are communicated from time to time by **DAVIS** to **PROVIDER.** Such compensation amounts are hereby incorporated by reference. Such compensation amounts are and shall be deemed to be full compensation for the Covered Services provided by **PROVIDER** to Members under applicable Plan(s) pursuant to this Agreement.

.2 **Copayments, Deductibles and Discount**. **PROVIDER** shall bill and collect all Copayments and Deductibles from Member(s), which are specifically permitted and/or applicable to Member(s)' benefit plan. **PROVIDER** shall bill and collect all charges from a Member for those Non-Covered Services provided to a Member. **PROVIDER** may only bill the Member when **DAVIS** has denied prior authorization for the service(s) and when the following conditions are met:

(a) The Member has been notified by the **PROVIDER** of the financial liability in advance of the service delivery;

(b) The notification by the **PROVIDER** is in writing, specific to the service being rendered, and clearly states that the Member is financially responsible for the specific service. A general patient liability statement which is signed by all patients is not sufficient for this purpose;

(c) The notification is dated and signed by the Member; and

(d) To the extent permitted by law, **PROVIDER** shall provide to Members either a courtesy discount of twenty percent (20%) off of **PROVIDER**'s usual and customary fees for the purchase of materials not covered by a Plan(s), and/or a discount of ten percent (10%) off of **PROVIDER**'s usual and customary fees for disposable contact lenses.

.3 **Financial Incentives**. **DAVIS** shall not provide **PROVIDER** with any financial incentive to withhold Covered Services, which are Medically Appropriate. Further, the parties hereto agree to comply with and to be bound by, to the same extent as if the sections were restated in their entirety herein, the provisions of 42 CFR §417.479 and 42 CFR §434.70, as amended by the final rule effective January 1, 1997,

and as promulgated by the CMS (formerly the Health Care Financing Administration, DHHS). In part, these sections govern physician incentive plans operated by Federally qualified health maintenance organizations and competitive medical plans contracting with the Medicare program, and certain health maintenance organizations and health insuring organizations contracting with the Medicaid program. As applicable and pursuant to 42 CFR §417.479 and 42 CFR §434.70, no specific payment will be made directly or indirectly, under Plans hereunder to a physician or physician group, as an inducement to reduce or limit medically necessary services furnished to a Member.

.4 **Member Billing/Hold Harmless**. Notwithstanding anything herein to the contrary, **PROVIDER** agrees that **DAVIS**' payment hereunder constitutes payment in full and except as otherwise provided for in a Member's benefit plan, **PROVIDER** shall look only to **DAVIS** for compensation for Covered Services provided to Members and shall at no time seek compensation from Members, from the MCO, the Plan, or the MAP for Covered Services even if **DAVIS** for any reason, including insolvency or breach of this Agreement, fails to pay **PROVIDER**. No surcharge to any Member shall be permitted. A surcharge shall, for purposes of this Agreement, be deemed to include any additional fee not provided for in the Member's benefit plan. This hold harmless provision supersedes any oral or written agreement to the contrary, shall survive termination of this Agreement regardless of the reason for termination, shall be construed to be for the benefit of the Member(s) and shall not be changed without the approval of appropriate regulatory authorities.

.5 **Payment of Compensation**. Payment shall be made to **PROVIDER** within thirty (30) days of receipt of a Clean Claim by **DAVIS or in accordance with the applicable state's prompt pay statute, whichever is least restrictive**. Notwithstanding anything herein to the contrary, **PROVIDER** shall bill **DAVIS** for all Covered Services rendered to a Member less any Copayment and Deductible collected or to be collected from the Member. For all Covered Services rendered by **PROVIDER** to a Member hereunder, **PROVIDER** shall, within sixty (60) days following the provision of Covered Services, submit to **DAVIS** an invoice. (Such invoice may be written, electronic or verbal, and shall be approved as to form and content by **DAVIS**). Failure of **PROVIDER** to submit said invoice within sixty (60) days of service delivery will, at **DAVIS'** option, result in nonpayment by **DAVIS** to **PROVIDER** for the Covered Services rendered. If **PROVIDER** is indebted to **DAVIS** for any reason, including, but not limited to, erroneous claim payments or payments due for materials and supplies, **DAVIS** may offset such indebtedness against any compensation due to **PROVIDER** pursuant to this Agreement.

.6 **Plan Hold Harmless Provisions**. **PROVIDER** agrees that he/she/it shall look only to **DAVIS** for compensation for Covered Services as set forth above and shall hold harmless each Plan from any obligation to compensate **PROVIDER** for Covered Services.

V
OBLIGATIONS OF PROVIDER

.1 **Access to Records**. To the extent applicable and necessary for **DAVIS** and/or Plan(s) to meet their respective data reporting and submission obligations to CMS, or other appropriate governmental agency; **PROVIDER** shall provide to **DAVIS** and/or Plan(s) all data and information in **PROVIDER**'s possession. Such information shall include, but shall not be limited to the following:

.1.1 any data necessary to characterize the context and purposes of each encounter with a Member, including without limitation, appropriate diagnosis codes applicable to a Member; and

.1.2 any information necessary for Plan(s) to administer and evaluate program(s); and

.1.3 as requested by **DAVIS**, any information necessary (a) to show establishment and facilitation of a process for current and prospective Medicare Advantage Members to exercise choice in obtaining Covered Services; (b) to report disenrollment rates of Medicare Advantage Members enrolled in Plan(s) for the previous two (2) years; (c) to report Medicare Advantage Member satisfaction; and (d) to report health outcomes; and

.1.4 any information and data necessary for **DAVIS** and/or Plan(s) to meet the physician incentive disclosure obligations under Medicare Laws and CMS instructions and policies; and

.1.5 any data necessary for **DAVIS** and/or Plan(s) to meet their respective reporting obligations under 42 C.F.R. § 422.516 and 42 C.F.R. § 422.257.

.1.6 Further, **PROVIDER** shall certify the accuracy, completeness and truthfulness of **PROVIDER**-generated encounter data that **DAVIS** and/or Plan(s) are obligated to submit to CMS.

.2 **COB Obligation of PROVIDER**. **PROVIDER** shall cooperate with **DAVIS** with respect to Coordination of Benefits (COB) and will bill and collect from other payer(s) such charges for which the other payer(s) is responsible. **PROVIDER** shall report all payments and collections received and attach all Explanations of Benefits (EOBs) in accordance with this Section V.2 to **DAVIS** when billing is submitted for payment.

.3 **Compliance with Law and Ethical Standards**. During the term of this Agreement, **PROVIDER** and **DAVIS** shall at all times comply with all applicable Federal, state or municipal statutes or ordinances, all applicable rules and regulations, and the ethical standards of the appropriate professional society. If at any time during the term of this Agreement, **PROVIDER'**s license to operate or to practice his/her/its profession is suspended, conditioned or revoked, **PROVIDER** shall timely notify **DAVIS** and without regard to a final adjudication or disposition of such suspension, condition or revocation, this Agreement shall immediately terminate, become null and void, and be of no further force or effect, except as provided herein. **PROVIDER** agrees to cooperate with **DAVIS** so that **DAVIS** may meet any requirements imposed on **DAVIS** by state and Federal law, as amended, and all regulations issued pursuant thereto.

.4 **Compliance with DAVIS Rules**. **PROVIDER** agrees to be bound by all of the provisions of the rules and regulations of **DAVIS** including, without limitation, those set forth in the Provider Manual. **PROVIDER** recognizes that from time to time **DAVIS** may amend such provisions and that such amended provisions shall be similarly binding on **PROVIDER**. **PROVIDER** agrees to cooperate with any administrative procedures adopted by **DAVIS** regarding the performance of Covered Services pursuant to this Agreement.

(a) To the extent that a requirement of the Medicare Advantage, or Medicaid Program is found in a policy or other procedural guide of **DAVIS,** Plan(s), DHHS or other government agency, and is not otherwise specified in this Agreement, **PROVIDER** will comply and agrees to require its employees, agents, subcontractors and independent contractors to comply with such policies, manuals, and procedures with regard to the provision of Covered Services to Members of such Programs.

(b) In the provision of Covered Services to Members, **PROVIDER** agrees to comply, and agrees to require its employees, agents, subcontractors and independent contractors to comply with all applicable laws and administrative requirements; including but not limited to Medicare and Medicaid laws and regulations, CMS instructions and policies, MAP regulations, and **DAVIS**' and Plan(s)' policies regarding credentialing, re-credentialing, utilization review, quality improvement, performance improvement, medical management, external quality reviews, peer review, complaint, grievance resolution and appeals

processes, comparative performance analysis, and enforcement and monitoring by appropriate government agencies.

(c) **PROVIDER** acknowledges and agrees that in relation to the provision of Covered Services to Medicare Advantage Members and Plan(s) hereunder, **PROVIDER**, and **PROVIDER**'s employees, agents, subcontractors, and independent contractors, must meet all applicable Medicare Advantage credentialing requirements. **PROVIDER** acknowledges and understands that the Medicare Advantage Plan is ultimately responsible to CMS for performance of such services; such services shall be monitored by the Plan(s); and the Plan(s) retain the right to approve, suspend, or to terminate any **PROVIDER** from such Plan(s).

.5 **Confidentiality of Member Information**. **PROVIDER** shall be bound by the same standards of confidentiality which apply to the MAP and the State, including unauthorized uses of or disclosures of personal health information.

(a) **PROVIDER** shall safeguard all information about Members according to applicable State and Federal laws and regulations. All material and information, in particular information relating to Members which is provided due to or obtained by or through **PROVIDER**'s performance under this Agreement, whether verbal, written, tape, or otherwise, shall be reported as confidential information to the extent confidential treatment is provided under State and Federal laws. **PROVIDER** shall not use any information so obtained in any manner except as necessary for the proper discharge of his/her/its obligations and securement of his/her/its rights under this Agreement.

(b) Neither **DAVIS** nor **PROVIDER** shall share confidential information with any Member(s)' employer, absent the Member(s)' written consent for such disclosure. **PROVIDER** agrees to comply with the requirements of the Health Insurance Portability and Accountability Act ("HIPAA") relating to the exchange of information and shall cooperate with **DAVIS** in its efforts to ensure compliance with the privacy regulations promulgated under HIPAA and other related privacy laws.

(c) **PROVIDER** and **DAVIS** acknowledge that the activities conducted to perform the obligations undertaken in this Agreement are or may be subject to HIPAA as well as the regulations promulgated to implement HIPAA. **PROVIDER** and **DAVIS** agree to conduct their respective activities, as described herein, in accordance with the applicable provisions of HIPAA and such implementing regulations. **PROVIDER** and **DAVIS** further agree that, to the extent HIPAA or such implementing regulations require amendments(s) hereto, **PROVIDER** and **DAVIS** shall conduct good faith negotiations to amend this Agreement.

.6 **Consent to Release Information**. Upon request by **DAVIS**, **PROVIDER** shall provide **DAVIS** with authorizations, consents or releases, as **DAVIS** may request in connection with any inquiry by **DAVIS** of any hospital, educational institution, governmental or private agency or association (including without limitation the National Practitioner Data Bank) or any other entity or individual relative to **PROVIDER'**s professional qualifications, **PROVIDER'**s mental or physical fitness, or the quality of care rendered by **PROVIDER**.

.7 **Cooperation with Plan Medical Directors**. **PROVIDER** understands that Plans will place certain obligations upon **DAVIS** regarding the quality of care received by Members and that Plans in certain instances will have the right to oversee and review the quality of care administered to Members. **PROVIDER** agrees to cooperate with Plan(s)' medical directors in the medical directors' review of the quality of care administered to Members.

.8 **Credentialing, Licensing and Performance**. **PROVIDER** agrees to comply with all aspects of **DAVIS'** credentialing and re-credentialing policies and procedures and the credentialing and re-credentialing policies and procedures of any Plan contracting with **DAVIS**. **PROVIDER** agrees that he/she/it shall be duly licensed by the state in which services are to be rendered and that he/she/it shall hold Diagnostic Pharmaceutical Authorization (DPA) certification to provide Dilated Fundus Examinations (DFE). Further, **PROVIDER** shall assist and facilitate in the collection of applicable information and documentation to perform credentialing and re-credentialing of **PROVIDER** as required by **DAVIS** and Plan(s). Such documentation may include proof of: licensure, certification, provider application, professional liability insurance coverage, undergraduate and graduate education and professional background. **PROVIDER** agrees that **DAVIS** shall have the right to source verify the accuracy of all information provided, and at **DAVIS**' sole option, the right to remove from Network participation any professional for whom inadequate, inaccurate, or otherwise unacceptable information is provided. **PROVIDER** agrees that at all times, and to the extent of his/her/its knowledge, **PROVIDER** shall promptly notify **DAVIS** in the event that **PROVIDER** suffers a suspension or termination of his/her/its license or of his/her/its professional liability insurance coverage. **PROVIDER** shall devote the time, attention and energy necessary for the competent and effective performance of **PROVIDER'**s duties hereunder to Member(s). **PROVIDER** shall use his/her/its best efforts to ensure that vision care services provided under this Agreement are of a quality that is consistent with accepted professional practices. **PROVIDER** agrees to abide by the standards established by **DAVIS** including, but not limited to, standards relating to the utilization and quality of vision care services.

.9 **Fraud/Abuse and Office Visits**. Upon the request of the CMS, the DHHS, the MAP, or other appropriate external review organization or regulatory agency ("Oversight Entities") **PROVIDER** shall make available all administrative, financial, medical, and all other records that relate to the delivery of items or services under this Agreement. **PROVIDER** shall provide all such access to the aforementioned records in the form and format requested and at no cost to **DAVIS** and/or to the requesting Oversight Entity. Further, the **PROVIDER** shall allow such Oversight Entities access to these records during normal business hours, except under special circumstances when **PROVIDER** shall permit after hours access. **PROVIDER** shall cooperate with all office visits made by **DAVIS** or any Oversight Entity.

.10 **Hours and Availability of Services**. Pursuant to and in accordance with 42 CFR 438.206(c)(1), **PROVIDER** and Participating Provider(s) agree to be available to provide Covered Services for Medically Appropriate care, taking into account the urgency of the need for services and when necessary and appropriate, to provide Covered Services for Medically Appropriate emergency care. **PROVIDER** and Participating Provider(s) shall ensure that Members will have access to either an answering service, a pager number, and/or an answering machine, twenty-four (24) hours per day, seven (7) days per week, in order that Members may ascertain **PROVIDER**'s office hours, have an opportunity to leave a message for the **PROVIDER** and/or Participating Provider(s) regarding a non-emergent concern and to receive pre-recorded instructions with respect to the handling of an emergency. .

(a) **PROVIDER** agrees that **PROVIDER** is subject to regular monitoring of his/her/its compliance with the appointment wait time (timely access) standards of 42 CFR 438.206(c)(1). As such **PROVIDER** agrees and understands that corrective action shall be implemented should **PROVIDER** and/or Participating Provider(s) fail to comply with timely access standards and that Plan(s) have the right to approve **DAVIS**' scheduling and administration standards.

(b) **PROVIDER** agrees to provide **DAVIS** with ninety (90) days notice, or such notice as is reasonably possible, if **PROVIDER** and/or Participating Provider shall (a) be unavailable to provide Covered Services to Members, (b) move his/her/its office location, or (c) reduce capacity at an office location. Under no circumstance shall provision of Covered Services to Members by **PROVIDER** be denied, delayed, reduced or hindered because of the financial or contractual relationship between **PROVIDER** and **DAVIS**.

.11 **Indemnification**. **PROVIDER** shall indemnify and hold harmless **DAVIS**, the Plan(s) and the State and their respective agents, officers and employees against all injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses which, in any manner may accrue against **DAVIS**, the Plan(s) or the State, and their respective agents, officers, or employees through **PROVIDER**'s intentional conduct, negligent acts or omissions, or the intentional conduct, negligent acts or omissions of **PROVIDER**'s employees, agents, affiliates, subcontractors, or independent contractors.

.12 **Malpractice Insurance**. **PROVIDER** shall, at **PROVIDER**'s sole cost and expense and throughout the entire term of this Agreement, maintain a policy (or policies) of professional malpractice liability insurance in a minimum amount of One Million Dollars ($1,000,000.00) per occurrence and Three Million Dollars ($3,000,000.00) in the annual aggregate, to cover any loss, liability or damage alleged to have been committed by **PROVIDER**, or **PROVIDER'**s agents, servants, employees, affiliates, independent contractors and/or subcontractors, and **PROVIDER** shall provide evidence of such insurance to **DAVIS** if so requested. In addition, and in the event the foregoing policy (or policies) is a "claims made" policy, **PROVIDER** shall, following the effective termination date of the foregoing policy, maintain "tail coverage" with the same liability limits.

(a) **PROVIDER** shall cause his/her/its employed, affiliated, independent or subcontracted Participating Provider(s) to substantially comply with Article V.12 above, and throughout the term of this Agreement and upon **DAVIS**' request, **PROVIDER** shall provide evidence of such compliance to **DAVIS**.

.13 **Nondiscrimination**. Nothing contained herein shall preclude **PROVIDER** from rendering care to patients who are not covered under one or more of the Plans; provided that such patients shall not receive treatment at preferential times or in any other manner preferential to Member(s)s covered under one or more of the Plans or in conflict with the terms of this Agreement. In accordance with Title VI of the Civil rights Act of 1964 (45 CFR 84) and The Age Discrimination Act of 1975 (45 CFR 91) and The Rehabilitation Act of 1973, and the Americans with Disabilities Act, **PROVIDER** agrees not to differentiate or discriminate as to the quality of service(s) delivered to Members because of a Member's race, gender, marital status, veteran status, age, religion, color, creed, sexual orientation, national origin, disability, place of residence, health status, need for services, or method of payment; and **PROVIDER** agrees to promote, observe and protect the rights of Members. Pursuant to and in accordance with 42 CFR 438.206(c)(2), **PROVIDER** and Participating Provider(s) agree that Covered Services hereunder shall be provided in a culturally competent manner to all Members, including those with limited English proficiency and diverse cultural and ethnic backgrounds. Further, **PROVIDER** understands that payments for Covered Services hereunder may, in whole or in part, be from Federal funds and that **PROVIDER** is subject to applicable laws related to the receipt of Federal funds, including any applicable portions of the U.S. Department of Health and Human Services, revised Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons ("Revised DHHS LEP Guidance"). During the term of this Agreement, **PROVIDER** shall not discriminate against any employee or any applicant for employment with respect to any employee's or applicant's hire, tenure, terms, conditions, or privileges of employment due to such individual's race, color, religion, gender, disability, marital status or national origin.

.14 **Notice of Non-Compliance and Malpractice Actions**. **PROVIDER** shall notify **DAVIS** immediately, in writing, should he/she/it be in violation of any portion of this Article V. Additionally, **PROVIDER** shall advise **DAVIS** of each malpractice claim filed against **PROVIDER** and each settlement or other disposition of a malpractice claim entered into by **PROVIDER** within fifteen (15) days following said filing, settlement or other disposition.

.15 **Participation Criteria**. **PROVIDER** hereby warrants and represents that **PROVIDER**, and all of his/her/its employees, affiliates, subcontractors and/or independent contractors who provide Covered Services under this Agreement, including without limitation health care, utilization review, and/or administrative services currently meet, and throughout the Term of this Agreement shall continue to meet any and all applicable conditions necessary to participate in the Medicare/Medicare Advantage program. **PROVIDER** hereby warrants and represents that **PROVIDER**, and all of **PROVIDER**'s employees, affiliates, subcontractors, and/or independent contractors are not excluded, sanctioned or barred from participation under a Federal health care program as described in Section 1128B(f) of the Social Security Act, and that all employees, affiliates, subcontractors, and/or independent contractors of **PROVIDER** are able to provide a current Universal Provider Identification Number and/or National Provider Identifier.

(a) **PROVIDER** understands and agrees that meeting the Participation Criteria is a condition precedent to **PROVIDER**'s participation, and a condition precedent to the participation by **PROVIDER**'s employees, affiliates, subcontractors, and/or independent contractor(s) hereunder and, is an ongoing condition to the provision of Covered Services hereunder by both the **PROVIDER** as well as a condition precedent to the reimbursement by **DAVIS** for such Covered Services rendered by **PROVIDER**. Upon **PROVIDER**'s meeting all of the Participation Criteria set forth in this Agreement **PROVIDER** shall participate as a Participating Provider for Plan(s)/Product programs covered under this Agreement.

(b) **PROVIDER** may not employ, contract with, or subcontract with an individual, or with an entity that employs, contracts with, or subcontracts with an individual, who is excluded from participation in Medicare under Section 1128 or 1128A of the Social Security Act or from participation in a Federal health care program for the provision of any of the following: (a) health care, (b) utilization review, (c) medical social work or (d) administrative services. **PROVIDER** acknowledges that this Agreement shall automatically be terminated if **PROVIDER**, any practitioner, or any person with an ownership or control interest in **PROVIDER**, is excluded from participation in Medicare under Section 1128 or 1128A of the Social Security Act or from participation in any other Federal health care program. Any payments received by **PROVIDER** hereunder on or after the date of such exclusion shall constitute overpayments.

.16 **PROVIDER Roster**. **PROVIDER** agrees that **DAVIS** and each Plan which contracts with **DAVIS** may use **PROVIDER'**s name, address, telephone number, type of practice, and willingness to accept new patients in the **DAVIS** or in the Plan roster of Participating Provider(s). The roster is intended for and may be inspected and used by prospective patients and others.

.17 **Record Retention**. **PROVIDER** shall maintain adequate and accurate medical, financial and administrative records related to Covered Services rendered by **PROVIDER** in accordance with Federal and State law. **PROVIDER** shall have written policies and procedures for storing all records.

(a) Pursuant to 42 CFR 422.504 and in accordance with CMS regulations, **PROVIDER** and **PROVIDER**'s employees, affiliates, subcontractors and independent contractors agree to maintain and safeguard contracts, books, documents, papers, records and Member medical records pertaining to and pursuant to **PROVIDER**'s performance of **PROVIDER**'s obligations under a Medicare or Medicare Advantage program hereunder, and agrees to provide such information to **DAVIS,** to contracting Plans, to

applicable state and Federal regulatory agencies, including but not limited to the DHHS, the Office of the Comptroller General or their designees, for inspection, evaluation, and audit. **PROVIDER** agrees to retain such books and records for a term of at least ten (10) years from the final date of the contract period or from the date of completion of any audit, whichever is later. In the case of a minor Member, **PROVIDER** shall retain such information for a minimum of ten (10) years after the time such minor attains the age of majority or ten (10) years from the final date of the contract period or from the date of completion of an audit, whichever is later.

(b) All hard copy or electronic records, including but not limited to working papers or information related to the preparation of reports, medical records, progress notes, charges, journals, ledgers, and fiscal reports, which are originated or are prepared in connection with and pursuant to **PROVIDER**'s performance of **PROVIDER**'s obligations under a Medicaid program hereunder, will be retained and safeguarded by the **PROVIDER** and **PROVIDER**'s employees, affiliates, subcontractors and independent contractors, in accordance with applicable sections of the Federal and State regulations. Records stored electronically must be produced at the **PROVIDER**'s expense, upon request, in the format specified by State or Federal authorities. All such records must be maintained for a minimum of six (6) years from the termination date of this Agreement or, in the event that the **PROVIDER** has been notified that State or Federal authorities have commenced an audit or investigation of this Agreement, or the provision of services by the **PROVIDER**, **PROVIDER**'s subcontractor or independent contractor, until such time as the matter under audit or investigation has been resolved, whichever is later.

(c) **PROVIDER**'s obligations contained in Section V.17 herein shall survive termination of this Agreement.

.18 **Subcontractors**. **PROVIDER** agrees that if **PROVIDER** enters into subcontracts or lease arrangements to render any health/vision care services that are permitted under the terms of this Agreement, **PROVIDER**'s subcontracts or lease arrangements shall include the following:

(a) an agreement by the subcontractor or leaseholder to comply with all of **PROVIDER**'s obligations in this Agreement; and

(b) a prompt payment provision as negotiated by **PROVIDER** and the subcontractor or leaseholder; and

(c) a provision setting forth the terms of payment and any additional payment arrangements; and

(d) a provision setting forth the term of the subcontract or lease (preferably a minimum of one [1] year); and

(e) the dated signature of all parties to the subcontract.

.19 **Training Regarding the Plan Contracts**. **PROVIDER** agrees to train his/her/its Participating Providers and staff at all Participating Offices regarding the fees and benefit or plan designs for Plan Contracts.

.20 **Verification of Eligibility**. **PROVIDER** shall verify eligibility of Member(s) by calling the appropriate toll-free (800/888) number supplied by **DAVIS** or by receiving from Member(s) a valid pre-certified voucher.

VI
TERM OF THE AGREEMENT

.1 **Term**. This Agreement shall become effective on the Effective Date appearing on the signature page herein, and shall thereafter be effective for an initial term of twelve (12**)** months.

.2 **Renewals**. Unless this Agreement is terminated in accordance with the termination provisions herein, this Agreement shall automatically renew for up to, but not more than, three (3) successive twelve (12) month terms on the same terms and conditions contained herein.

VII
TERMINATION OF THE AGREEMENT

.1 **Termination Without Cause**. After the initial twelve (12) month term has ended, this Agreement may be terminated by either party without cause, upon ninety (90) days prior, written notice. If **DAVIS** elects to terminate this Agreement other than at the end of the initial term hereof, or for a reason other than those set forth in Sections VII.1 and VII.2 hereof, **PROVIDER** may request a hearing before a panel appointed by **DAVIS**. Such hearing will be held within thirty (30) days of receipt of **PROVIDER**'s request.

.2 **Termination With Cause**. **DAVIS** may terminate this Agreement immediately for cause or may suspend continued participation as set forth below. "Cause" shall mean:

(a) a suspension, revocation or conditioning of **PROVIDER'**s license to operate or to practice his/her/its profession;

(b) a suspension, or a history of suspension, of **PROVIDER** from Medicare or Medicaid;

(c) conduct by **PROVIDER** which endangers the health, safety or welfare of Members;

(d) any other material breach of any obligation of **PROVIDER** under the terms of this Agreement;

(e) a conviction of a felony;

(f) a loss or suspension of a Drug Enforcement Administration (DEA) identification number;

(g) a voluntary surrender of **PROVIDER**'s license to practice in any state in which the **PROVIDER** serves as a **DAVIS** Provider while an investigation into the **PROVIDER**'s competency to practice is taking place by the state's licensing authority;

(h) the bankruptcy of **PROVIDER.**

"Cause" for the purposes of suspension shall mean:

(a) a failure by **PROVIDER** to maintain malpractice insurance coverage as provided in Section V.12 hereof;

(b) a failure by **PROVIDER** to comply with applicable laws, rules, regulations, and ethical standards as provided in Section V.3 hereof;

(c) a failure by **PROVIDER** to comply with **DAVIS'** rules and regulations as required in Section V.4 hereof;

(d) a failure by **PROVIDER** to comply with the utilization review and quality management procedures described in Section IX.3 hereof;

(e) a violation by **PROVIDER** of the non-solicitation covenant set forth in Section X.8 hereof;

Provided, however, that **PROVIDER** shall not be penalized nor shall this Agreement be terminated or suspended because **PROVIDER** acts as an advocate for a Member in seeking appropriate Covered Services, or files a complaint or an appeal.

.3 **Termination Related to Medicare Advantage**. At the sole discretion of CMS, Plan(s) and/or **DAVIS**, this Agreement may be immediately terminated, as it relates to **PROVIDER**'s provision of Covered Services to Medicare Advantage Members hereunder for the following reasons:

.3.1 A decision by **DAVIS** and/or Plan(s) to discontinue its/their participation in the Medicare Advantage Programs; or

.3.2 A decision by **DAVIS** and/or Plan(s) to utilize another network for Medicare Advantage Programs; or

.3.3 A decision by CMS, Plan(s), and/or **DAVIS** that: (i) Provider has not performed satisfactorily, or (ii) Provider's reporting and disclosure obligations under this Agreement are not fully met or timely met; or

.3.4 The failure of **PROVIDER** to comply with the equal access and non-discrimination requirements set forth in this Agreement.

.4 **Responsibility for Members at Termination**. In the event that this Agreement is terminated (other than for loss of licensure or failure to comply with legal requirements as provided in Section V hereof), **PROVIDER** shall continue to provide Covered Services to a Member who is receiving Covered Services from **PROVIDER** on the effective termination date of this Agreement for a minimum transitional period of sixty (60) days from the date the Member is notified of the termination or pending termination, or until the Covered Services being rendered to the Member by **PROVIDER** are completed (consistent with existing medical ethical and/or legal requirements for providing continuity of care to a Member), unless **DAVIS** or a Plan makes reasonable and Medically Appropriate provision for the assumption of such Covered Services by another Participating Provider. **DAVIS** shall compensate **PROVIDER** for those Covered Services provided to a Member pursuant to this Section VII.4 (prior to and following the effective termination date of this Agreement) at the rates contemplated for Covered Services in this Agreement.

(a) In consultation with Plan(s), the Member and/or the **PROVIDER** may extend the transitional period if it is determined to be clinically appropriate, or in order to comply with the requirements of applicable Plan documents and/or accrediting standards. **PROVIDER** shall continue to provide Covered Services to such Member(s) and the parties agree that all such Covered Services rendered shall be subject to the terms and conditions contained in this Agreement (including reimbursement rates) that are effective as of

the date of termination.

(b) Should **DAVIS** and/or Plan(s) initiate termination of this Agreement, **PROVIDER** acknowledges and agrees that **PROVIDER**'s obligations as set forth in this Section VII survive such termination.

.5 **PROVIDER Rights Upon Termination**. Except as otherwise required by law, **PROVIDER** agrees that, subject to the appeal process set forth in the Provider Manual, any **DAVIS** decision to terminate this Agreement pursuant to this Section VII shall be final.

(a) **PROVIDER** acknowledges that Plan(s) have the authority to determine whether a **PROVIDER** shall be suspended or terminated from participation in a particular Plan without termination of this Agreement However, Plan(s) shall not have the authority to terminate **PROVIDER** for (a) maintaining a practice that includes a substantial number of patients with expensive health conditions; (b) objecting to or refusing to provide a Covered Service on moral or religious grounds; (c) advocating for Medically Appropriate care consistent with the degree of learning and skill ordinarily possessed by a reputable health care provider practicing according to the applicable standard of care; (d) filing a grievance on behalf of and with the written consent of a Member or helping a Member to file a grievance; and (e) protesting a Plan decision, policy or practice that **PROVIDER** reasonably believes interferes with the provision of Medically Appropriate care.

.6 **Return of Materials, Payments of Amounts Due and Settlement of Claims**. Upon termination of this Agreement, **PROVIDER** shall return to **DAVIS** any Plan or **DAVIS** materials including, but not limited to frame samples, displays, manuals and contact lens materials, and shall pay **DAVIS** any monies due with respect to claims or for materials and supplies. **DAVIS** may setoff any monies due from **DAVIS** to **PROVIDER** if **PROVIDER** owes any monies to **DAVIS**. **DAVIS** may reclaim frame samples at any time during the term of this Agreement. **PROVIDER** agrees to promptly supply to **DAVIS** all records necessary for the settlement of outstanding medical claims.

.7 **Provider Notification to Members upon Termination**. Should **PROVIDER** terminate this Agreement pursuant to Section VII.1 above, or should a particular practitioner leave **PROVIDER's** practice or otherwise become unavailable to the Member(s) under this Agreement, **PROVIDER** agrees to notify said Member(s) prior to the effective date of such action or termination.

VIII
DOCUMENTATION AND AMENDMENT

.1 **Amendment**. This Agreement may be amended by **DAVIS** with thirty (30) days advance, written notice to **PROVIDER**.

.2 **Documentation**. **DAVIS** shall provide **PROVIDER** with a copy of any document(s) required by contracting Plan(s), which has been approved by **DAVIS** and requires **PROVIDER's** signature. If **PROVIDER** does not execute and return said document(s) within fifteen (15) calendar days of document receipt, or if **PROVIDER** does not provide **DAVIS** with a written notice of termination in accordance with the termination provision(s) contained herein, **DAVIS** may execute said document(s) as agent of **PROVIDER** and said document(s) shall be deemed to be executed by **PROVIDER**.

.3 **Modification of Law, Rules, Regulations**. Notwithstanding anything herein to the contrary, should any applicable Federal or State law(s) be amended and their implementing regulations, policy issuances and instructions be modified, no particular notice of amendment by **DAVIS** to **PROVIDER** shall be required. Such amended laws apply as of their respective effective dates and this Agreement shall automatically amend to conform to such changes without the necessity for executing written amendments. **DAVIS** shall however, employ its best efforts to notify **PROVIDER** of such occurrences within a practicable timeframe.

IX
UTILIZATION REVIEW, QUALITY MANAGEMENT, QUALITY IMPROVEMENT AND GRIEVANCE PROCEDURES

.1 **Access to Records**. **PROVIDER** shall make all records available for fiscal audit, medical audit, medical review, utilization review and other periodic monitoring upon request of Oversight Entities at no cost to the requesting entity.

(a) Upon termination of this Agreement for any reason, **PROVIDER** shall, in a useable form, make available to any Oversight Entities, all records, whether dental/medical or financial, related to **PROVIDER**'s activities undertaken pursuant to the terms of this Agreement at no cost to the requesting entity.

.2 **Consultation with Provider**. **DAVIS** agrees to consult with **PROVIDER** regarding **DAVIS**' medical policies, quality improvement program and medical management programs and ensure that practice guidelines and utilization management guidelines:

(a) are based on reasonable medical evidence or a consensus of health care professionals in the particular field;

(b) consider the needs of the enrolled population;

(c) are developed in consultation with Participating Providers who are physicians; and are reviewed and updated periodically; and

(d) are communicated to Participating Providers of the Plan(s) and as appropriate to the Members.

.3 **Establishment of UR/QM Programs**. Utilization review and quality management programs shall be established to review whether services rendered by **PROVIDER** were Medically Appropriate and to determine the quality of Covered Services furnished by **PROVIDER** to Members. Such programs will be established by **DAVIS**, in its sole and absolute discretion, and will be in addition to any utilization review and quality management programs required by a Plan. **PROVIDER** shall comply with and, subject to **PROVIDER'**s rights of appeal, shall be bound by all such utilization review and quality management programs. If requested, **PROVIDER** may serve on the utilization review and/or quality management committee of such programs in accordance with the procedures established by **DAVIS** and Plans. Failure to comply with the requirements of this Section IX.3 may be deemed by **DAVIS** to be a material breach of this Agreement and may, at **DAVIS'** option, be grounds for immediate termination by **DAVIS** of this Agreement. **PROVIDER** agrees that decisions of the **DAVIS** designated utilization review and quality management committees may be used by **DAVIS** to deny **PROVIDER** payment hereunder for those Covered Services provided to a Member which are determined to not be Medically Appropriate or of poor quality or to be services for which **PROVIDER** failed to receive a prior authorization to treat a Member.

.4 **Grievance Procedures**. A grievance procedure shall be established for the processing of any Member or **PROVIDER** complaint regarding Covered Services. Such procedure will be established by **DAVIS** and contracting Plans, in their sole and absolute discretion. **PROVIDER** shall comply with and subject to **PROVIDER'**s rights of appeal be bound by such grievance procedure.

.5 **Provider Cooperation with External Review**. **PROVIDER** shall cooperate and provide Plans, **DAVIS**, government agencies and any external review organizations ("Oversight Entities") with access to each Member's vision records for the purposes of quality assessment, service utilization and quality improvement, investigation of Member(s)' complaints or grievances or as otherwise is necessary or appropriate.

.6 **Provider Participation/Cooperation with UR/QM Programs**. As applicable, **PROVIDER** agrees to participate in, cooperate and comply with, and abide by decisions of **DAVIS**, MCO, and/or Plan(s) with respect to **DAVIS**', MCO's, and/or Plan(s)' medical policies and medical management programs, procedures or activities; quality improvement and performance improvement programs, procedures and activities; and utilization and management review. **PROVIDER** further agrees to comply and cooperate with an independent quality review and improvement organization's activities pertaining to the provision of Covered Services for Medicare, Medicare Advantage, and MA Program Members.

X
GENERAL PROVISIONS

.1 **Arbitration**. Any controversy or claim arising out of or relating to this Agreement, or to the breach thereof, will be settled by arbitration in accordance with the commercial arbitration rules of the American Arbitration Association, and judgment upon the award rendered by the arbitrator(s) may be entered in any court having jurisdiction thereof. Such arbitration shall occur within the State of New York, unless the parties mutually agree to have such proceedings in some other locale. In any such proceeding, the arbitrator(s) may award attorneys' fees and costs to the prevailing party.

.2 **Assignment**. This Agreement shall be binding upon, and shall inure to the benefit of the parties to it and their respective heirs, legal representatives, successors and permitted assigns. Notwithstanding the foregoing, **PROVIDER** may not assign any of his/her/its rights or delegate any of his/her/its duties hereunder without receiving the prior, written consent of **DAVIS**.

.3 **Confidentiality of Terms/Conditions**. The terms of this Agreement and in particular the provisions regarding compensation are confidential and shall not be disclosed except as and only to the extent necessary to the performance of this Agreement or as required by law.

.4 **Entire Agreement of the Parties**. This Agreement supersedes any and all agreements, either written or oral, between the parties hereto with respect to the subject matter contained herein and contains all of the covenants and agreements between the parties with respect to the rendering of Covered Services. Each party to this Agreement acknowledges that no representations, inducements, promises, or agreements, oral or otherwise, have been made by either party, or anyone acting on behalf of either party, which are not embodied herein, and that no other agreement, statement, or promise not contained in this Agreement shall be valid or binding. Except as otherwise provided herein, any effective modification must be in writing signed by the party to be charged.

.5 **Governing Law**. This Agreement shall be governed by and construed in accordance with the laws of the state in which **PROVIDER** maintains his, her, or its principal office or, if a dispute concerns a

particular Member, in the state in which **PROVIDER** rendered services to that Member.

.6 **Headings**. The subject headings of the sections and sub-sections of this Agreement are included for purposes of convenience only and shall not affect the construction or interpretation of any of its provisions.

.7 **Independent Contractor**. At all times relevant to and pursuant to the terms and conditions of this Agreement, **PROVIDER** is and shall be construed to be an independent contractor practicing **PROVIDER'**s profession and shall not be deemed to be or construed to be an agent, servant or employee of **DAVIS**.

.8 **Non-Solicitation of Members**. During the term of this Agreement and for a period of two (2) years after the effective date of termination of this Agreement, **PROVIDER** shall not directly or indirectly engage in the practice of solicitation of Members, Plans or any employer of said Members without **DAVIS'** prior written consent. For purposes of this Agreement, a solicitation shall mean any action by **PROVIDER** which **DAVIS** may reasonably interpret to be designed to persuade or encourage (i) a Member or Plan to discontinue his/her/its relationship with **DAVIS** or (ii) a Member or an employer of any Member to disenroll from a Plan contracting with **DAVIS**. A breach of this Section X.8 shall be grounds for immediate termination of this Agreement.

.9 **Notices**. Should either party be required or permitted to give notice to the other party hereunder, such notice shall be given in writing and shall be delivered personally or by first class mail. Notices delivered personally will be deemed communicated as of actual receipt. Notices delivered via first class mail shall be deemed communicated as of three (3) days after mailing. Notices shall be delivered or mailed to the addresses appearing in the introductory paragraph on the first page of this Agreement. Either party hereunder may change its address by providing written notice in accordance with this Section X.9.

.10 **Proprietary Information**. **PROVIDER** shall maintain the confidentiality of all information obtained directly or indirectly through his/her/its participation with **DAVIS** regarding a Member, including but not limited to, the Member's name, address and telephone number ("Member Information"), and all other "**DAVIS** trade secret information". For purposes of this Agreement, "**DAVIS** trade secret information" shall include but shall not be limited to: (i) all **DAVIS** Plan agreements and the information contained therein regarding **DAVIS**, Plans, employer groups, and the financial arrangements between any hospital and **DAVIS** or any Plan and **DAVIS**, and (ii) all manuals, policies, forms, records, files (other than patient medical files), and lists of **DAVIS**. **PROVIDER** shall not disclose or use any Member Information or **DAVIS** trade secret information for his/her/its own benefit or gain either during the term of this Agreement or after the date of termination of this Agreement; provided, however, that **PROVIDER** may use the name, address and telephone number, and/or medical information of a Member if Medically Appropriate for the proper treatment of such Member or upon the express prior written permission of **DAVIS**, the Plan in which the Member is enrolled, and the Member.

.11 **Severability**. Should any provision of this Agreement be held to be invalid, void or unenforceable by a court of competent jurisdiction or by applicable state or Federal law and their implementing regulations, the remaining provisions of this Agreement will nevertheless continue in full force and effect.

.12 **Third Party Beneficiaries**.

(a) Plans. Plans are intended to be third-party beneficiaries of this Agreement. Plans shall be deemed, by virtue of this Agreement to have privity of contract with **PROVIDER** and may enforce any of the terms hereof.

(b) Other Persons. Other than the Plans and the parties hereto and their respective successors or assigns, nothing in this Agreement whether express or implied, or by reason of any term, covenant, or condition hereof, is intended to or shall be construed to confer upon any person, firm, or corporation, any remedy or any claim as third party beneficiaries or otherwise; and all of the terms, covenants, and conditions hereof shall be for the sole and exclusive benefit of the parties hereto and their successors and assigns.

.13 **Use of Name**. **PROVIDER** shall not use **DAVIS'** or any Plan's name or logo without the written authorization of **DAVIS** or such Plan.

.14 **Waiver**. The waiver of any provision or the waiver of any breach of this Agreement must be set forth specifically in writing and signed by the waiving party. Any such waiver shall not operate as or be deemed to be a waiver of any prior or any future breach of such provision or of any other provision contained herein.

IN WITNESS WHEREOF, the parties have set their hand hereto and this Agreement is effective as of the Effective Date written below.

DAVIS VISION, INC.:

By: _____
Name: _____
Date: _____
Title: _____
Effective Date: _____
[For DAVIS use only]

PROVIDER:

By: _____
Print Name: _____
Date: _____
Print Title: _____
FEIN (Tax ID#): _____
(PROVIDER MUST sign, print name, date, title, and Tax ID.)

***** Submission of a completed Vision Care Provider Application and/or submission of a signed Participating Provider Agreement does not constitute acceptance as a **DAVIS** Participating Provider. Acceptance as a Participating Provider is contingent on the acceptance by **DAVIS** of practitioner's completed Vision Care Provider Application and on the execution by practitioner of the Participating Provider Agreement and on the receipt by practitioner of the forms, manual and samples required for participation. **DAVIS** reserves the absolute right to determine which practitioner is acceptable for participation and in which groups a practitioner will participate. Following **DAVIS**' acceptance of a practitioner as a Participating **PROVIDER,** should additional licensed and credentialed practitioner(s) join **PROVIDER's** practice and provide Covered Services to the Members of Plans under Plan Contract(s) with **DAVIS**, such additional practitioner(s) shall be subject to and bound by each and every term and condition set forth in this Agreement to the same extent as the original signatories to this Agreement.

PROVIDER NUMBER: _____
[For DAVIS use only]

DAVIS VISION ™
THE EYECARE ADVANTAGE

VISION CARE PROVIDER APPLICATION
(PRACTITIONER INFORMATION)

1. IDENTIFICATION

Last Name:_____ First Name:_____ MI: ____
Degree(s): _____
Gender: ___ Date of Birth: ___/___/____ Maiden Name: _____
Social Security Number: _____
Are you proficient in any language, including American Sign Language, in addition to English? Yes ☐ No ☐ If yes, please list: _____
_____
_____
E-Mail Address: _____

2. GOVERNMENT PROGRAMS

Individual Medicaid Number 1: _____ State1: _____
Effective Date _____ Expiration Date: _____
Individual Medicaid Number 2: _____ State2: _____
Effective Date _____ Expiration Date: _____
Individual Medicare Number: _____
Effective Date _____ Expiration Date: _____
UPIN Number: _____
NPI Number:_____

3. CERTIFICATION INFORMATION

Optometrists:
Please check highest certification level achieved: DPA Certified: Yes ☐ No ☐
TPA Certified: Yes ☐ No ☐

MD/DO Board Certified: Yes ☐ No ☐
If "yes," provide Board Certification Date: ___/___/___
MD/DO Board Re-Certification Date: ___/___/___

For Davis Vision use only:
Practitioner Number: _____
Affiliated office Number: _____

Kit	☐	Kitless	☐	Exam	☐	Discount	☐
EPO	☐	PPO	☐	Assoc.	☐	Other	☐

DAVIS VISION ™
THE EYECARE ADVANTAGE

VISION CARE PROVIDER APPLICATION
(PRACTITIONER INFORMATION)

4. DISASTER/EMERGENCY INFORMATION

***Home Address:**_____
_____
_____
_____

*City: _____ *State: _____ *Zip: _____
*Home Phone: (_____) _____- _____ *Cell Phone: (_____) _____- _____
*Pager: (_____) _____- _____ *E-Mail Address: _____

*This information is requested in the event that we are unable to contact your office due to a natural disaster or other emergency.

5. CONFIDENTIALITY OF PATIENT INFORMATION

- Are Medical Records stored in a secure location within the office? Yes ☐ No ☐
- Is access to Medical Records restricted to authorized personnel? Yes ☐ No ☐

6. EDUCATION/TRAINING

Education

	School	Degree	Year Graduated
Undergraduate:	_____	_____	_____
Optometry/Medical:	_____	_____	_____
Other/Post Graduate:	_____	_____	_____

Training

Training Record 1 – Please check training type and complete other fields:

Training Type: ☐ Internship, ☐ Residency, ☐ Fellowship, ☐ Other

Institution Name: _____ Start Date: ___/___/___ End Date: ___/___/___
Address: _____
_____
_____
City: _____ State: _____ Zip: _____ Country: _____

DAVIS VISION ™
THE EYECARE ADVANTAGE

VISION CARE PROVIDER APPLICATION
(PRACTITIONER INFORMATION)

Training Record 2 – Please check training type and complete other fields:

Training Type: ☐ Internship, ☐Residency, ☐ Fellowship, ☐Other

Institution Name: _____ Start Date: ___/___/___ End Date: ___/___/___
Address: _____
_____
_____
City: _____ State: _____ Zip: _____ Country: _____

Please attach separate sheet(s) for additional training information; use same format.

7. LICENSURE

License Number	State	Date Issued	Date License Expires
_____	____	___/___/___	___/___/___
_____	____	___/___/___	___/___/___
_____	____	___/___/___	___/___/___
_____	____	___/___/___	___/___/___

Controlled Substance Registration Number (CSR)(If applicable): _____
Expiration Date: ___/___/___

DEA Number (If applicable): _____ Expiration Date: ___/___/___

8. PROFESSIONAL LIABILITY INSURANCE – PLEASE ATTACH A COPY OF CURRENT PROFESSIONAL LIABILITY POLICY (FACE SHEET OR CERTIFICATE OF INSURANCE)

Professional liability carrier name: _____
Policy Number: _____
Policy Start Date: ___/___/___ Policy End Date: ___/___/___
Coverage Limit Per Occurrence: $_____
Length of time with current carrier _____
Coverage Limit Aggregate: $ _____

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9. HOSPITAL AFFILIATION INFORMATION (If Applicable)

1. Hospital Name:____
   Address:____
   Dates Affiliated:______/______/______ to ______/______/______

2. Hospital Name:____
   Address:____
   Dates Affiliated:______/______/______ to ______/______/______

3. Hospital Name:____
   Address:____
   Dates Affiliated:______/______/______ to ______/______/______

**If you have additional affiliation information please attach a separate sheet; use same format.*

10. PROFESSIONAL EMPLOYMENT HISTORY (Please list your work experience for the preceding five (5) years, <u>beginning with your most current work information.</u> Provide an explanation on a separate sheet for any gaps in work history that are of a duration of six months or greater.) In addition, you may attach a current curriculum vitae/ resume'. *<u>ALL FIELDS BELOW ARE REQUIRED**</u>***

Year	**Location # 1 (include Address)**	**Dates**
_____	________________________________	___/__/___ through **Present**
	Location #2 (include Address)	**Dates**
	________________________________	___/__/___ through ___/___/___

Year	**Location #1 (include Address)**	**Dates**
_____	________________________________	___/__/___ through ___/___/___
	Location #2 (include Address)	**Dates**
	________________________________	___/__/___ through ___/___/___

Year	**Location #1 (include Address)**	**Dates**
_____	________________________________	___/__/___ through ___/___/___
	Location #2 (include Address)	**Dates**
	________________________________	___/__/___ through ___/___/___

Year	**Location #1 (include Address)**	**Dates**
_____	________________________________	___/__/___ through ___/___/___
	Location #2 (include Address)	**Dates**
	________________________________	___/__/___ through ___/___/___

Year	**Location #1 (include Address)**	**Dates**
_____	________________________________	___/__/___ through ___/___/___
	Location #2 (include Address)	**Dates**
	________________________________	___/__/___ through ___/___/___

Year	**Location #1 (include Address)**	**Dates**
_____	________________________________	___/__/___ through ___/___/___
	Location #2 (include Address)	**Dates**
	________________________________	___/__/___ through ___/___/___

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11. QUESTIONS (Other than an affirmative answer to question #1 below, all other affirmative answers should be detailed on a separate sheet.)

1. For each of the preceding five years, have you received a minimum of six (6) hours of continuing education credits per year, or the minimum number of credits per year that are mandated by the state in which you practice? Yes ☐ No ☐

2. Have you been convicted of a felony or are you currently under indictment for a criminal offense in any state? Yes ☐ No ☐

3. Have any of your licenses been sanctioned, placed on probation, suspended, or revoked in any state? Yes ☐ No ☐

4. Have you been subject to any disciplinary action by any professional organization or by any licensing authority? Yes ☐ No ☐

5. Has your participation status in Medicare and/or Medicaid ever been modified, sanctioned, suspended, or terminated? Yes ☐ No ☐

6. Have you been subject to any loss or limitation of clinical privileges by any facility or by any organization with which you previously had privileges? Yes ☐ No ☐

7. Has any claim or suit alleging malpractice against you as a defendant, or against you as a co-defendant ever been filed, pended, or appealed by you or by your insurance carrier on your behalf? Yes ☐ No ☐

8. Has any malpractice judgment/settlement ever been entered against you? If yes, please provide documentation from insurer. Yes ☐ No ☐

9. Has your malpractice (professional liability) insurance ever been restricted, special-rated, not renewed, suspended and/or cancelled? Yes ☐ No ☐

10. Have you ever been suspended or terminated from panel participation by any network or third party program or insurer? Yes ☐ No ☐

12. MD's

1. Have you been refused membership on any hospital medical staff? Yes ☐ No ☐

2. Have your privileges at any hospital been diminished, suspended, revoked or not renewed? Yes ☐ No ☐

3. Have you ever been denied membership or renewal of membership in any medical organization or have you been subject to any disciplinary action by any medical organization? Yes ☐ No ☐

DAVIS VISION ™
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VISION CARE PROVIDER APPLICATION
(PRACTITIONER INFORMATION)

ATTESTATION AND RELEASE OF INFORMATION

I understand and acknowledge that as an applicant for provider participation status with Davis Vision, Inc. for either initial credentialing, or re-credentialing or update of information, I have the burden of producing adequate information for the proper evaluation of my professional qualifications, credentials, clinical competence, quality assurance and utilization data, character, mental health status, physical health status, alcohol or chemical dependency diagnosis and treatment, or other criteria used for determining eligibility for participation status with Davis Vision, Inc.

I affirm that the information provided in this Application for participation status is current, accurate, and complete as of the signature date below, and I understand and agree that any misstatements in and/or omissions from the information provided herein may constitute cause for denial of my Application and/or summary dismissal or termination of participation status with Davis Vision, Inc., and I further agree to immediately notify Davis Vision, Inc. of any change to the information provided in this Application. I understand that any information provided in this Application that is not publicly available will be treated as confidential by Davis Vision, Inc., unless otherwise permitted to be disclosed by law.

I further understand and acknowledge that Davis Vision, Inc., its employees and agents will investigate the information in this Application, as well as any oral and written statements, records and documents concerning my Application for participation status, and I agree to such investigation and to the disciplinary reporting and information exchange activities of Davis Vision, Inc. as part of the verification and credentialing process.

I consent to the inspection of all oral and written statements, records and documents that may be material to an evaluation of my qualifications and to my ability to carry out or to provide the services required or requested for participation status, and I authorize each and every individual and organization in custody of such statements, records and documents to permit such inspection and copying; and I further agree to permit Davis Vision, Inc. to source verify credentials and to access the National Practitioners Data Bank (NPDB) and other pertinent sources for history; and I further consent and am willing to make myself available to appear for interviews if required or requested.

I authorize Davis Vision, Inc. and its affiliates, subsidiaries or related entities to consult with hospital administrators, members of medical staff of hospitals, malpractice insurance carriers, licensing boards, professional and/or educational organizations, and other person(s) to obtain and verify information; and I further release Davis Vision, Inc. and its employees and agents from any and all liability for their acts performed in good faith and without malice or misconduct, in obtaining and verifying such information and in evaluating my Application.

I consent to the release by any person, to Davis Vision, Inc., of any and all information that may be reasonably relevant to an evaluation of my professional competency, character, ability to practice in the areas in which I have requested privileges, and to my moral and ethical qualifications, including any information relating to any disciplinary action, suspension, limitation, or revocation of privileges.

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VISION CARE PROVIDER APPLICATION
(PRACTITIONER INFORMATION)

I hereby release from any and all liability, each and every individual, organization, and/or third party that, in good faith and without malice or misconduct, provides information to Davis Vision, Inc., concerning my professional qualifications and competence.

I further acknowledge and understand that this authorization and consent to release information is for the purpose of permitting Davis Vision, Inc., its employees and agents to update my data, conduct office and record reviews and to conform with the National Committee for Quality Assurance (NCQA) standards, and that this authorization is irrevocable for any period of time during which I am an applicant for, or a provider in, the Davis Vision, Inc. network; and I agree to execute another form of authorization and consent if law or regulation limits the application of this irrevocable authorization; and I understand that my failure to promptly execute and provide such other authorization and consent may be grounds for termination or discipline by Davis Vision, Inc. in accordance with Davis Vision's rules and requirements for network participation status.

I understand and acknowledge that neither the submission of a completed Davis Vision, Vision Care Provider Application nor the execution of the Davis Vision Participating Provider Agreement constitutes acceptance as a Davis Vision Participating Provider. Acceptance as a Davis Vision Participating Provider is contingent on the acceptance by Davis Vision, Inc. of an applicant's completed Application, and on the execution by the applicant of the Davis Vision Participating Provider Agreement, and on the receipt by the applicant of the forms, manual and samples required for participation. Davis Vision, Inc. reserves the absolute right to determine which applicant is acceptable for participation and in which groups an applicant will participate.

I acknowledge that I have read and understand the foregoing Attestation and Release of Information. I understand that if my Application is rejected for reasons relating to my professional conduct or competence, Davis Vision, Inc. may report the rejection to the appropriate state licensing board and/or the NPDB. A photocopy of this Attestation and Release of Information shall be as effective as the original, and this authorization constitutes my written authorization and request to communicate any relevant information and to release any and all supportive documentation regarding this Application/Attestation and Release.

I understand that the provider's Bill of Rights and non-discrimination policy is available for viewing at **www.davisvision.com**.

***Signature:** _____ **Date:** ___/___/___

***Print Name:** _____

*(Applicant/Practitioner must sign and print name in full. Modification to the wording or format of this Attestation and Release of Information may invalidate the Application.)

Contact Lens Formularies

All formulary A and B Contact Lenses are at set copay amounts.

Formulary B Contact Lenses have higher copay amounts than Formulary A.

Contact Lens Formulary: Under most Davis Vision Programs, eligible members are entitled to receive contact lenses in lieu of eyeglasses. Many of those programs include a formulary consisting of various spherical soft contact lenses that are supplied by Davis Vision without cost to the provider. The lenses included within Plan Formularies were selected to give you maximum flexibility in choosing the ideal lens for your patient's needs. The table reflects a current list of all contact lens types supplied by Davis Vision (i.e. "plan supplied") under our comprehensive benefit programs. When Plan Supplied contact lenses are provided, Davis Vision pays a professional fitting fee to the participating provider. All other lens types are supplied by the provider according to the non-plan allowance. Please refer to the group specific Service Record Form, Plan Outline or Personalized Service Record Form (PSRF) for applicable patient charges, copayment or allowance amounts.

FORMULARY A

Type	Lens	Manufacturer
D	Optima FW 6 pk	Bausch & Lomb®
D	Soflens 66	Bausch & Lomb®
D	B&L 2 week (A.K.A. Soflens 59)	Bausch & Lomb®
D	Precision UV	CIBA Vision®
DW	D2LT	CIBA Vision®
DW	D3LT	CIBA Vision®
D	Freshlook LT	CIBA Vision®
D	Focus Dailies - 30 Pk	CIBA Vision®
DW	Standard Visitint	CIBA Vision®
DW	Visitint	CIBA Vision®
PR	Frequency 38 (**)	Cooper Vision®
PR	Frequency 55 (**)	Cooper Vision®
DW	Z4 Sofblue	Ocular Sciences
DW	Z6 Sofblue	Ocular Sciences
D	Biomedics 38	Ocular Sciences
D	Biomedics 55	Ocular Sciences
DW	Proactive	Ocular Sciences
DW	Silver 07	Ocular Sciences

FORMULARY B

Type	Lens	Manufacturer
DW	CSI	CIBA Vision®
PR	Focus Monthly (**)	CIBA Vision®
D	Focus 1-2 Week	CIBA Vision®
DW	Cooper Clear	Cooper Vision®
D	Acuvue	Johnson & Johnson
D	Acuvue 2	Johnson & Johnson
D	Acuvue Advance	Johnson & Johnson
D	1-Day Acuvue	Johnson & Johnson

Key to Lens Types

D=Disposable DW=Daily-wear PR=Planned Replacement

Note: (**) Both new and existing wearers will only receive 2 boxes due to the extended wearing period of this lens.

For new wearers of all D & PR - 2 boxes, up to a 3 months supply will be provided (with the exception of daily disposable lenses).

For existing wearers of all D - 4 boxes, up to 6 months supply will be provided (with the exception of daily disposable lenses).

Progressive Addition Lenses (PALs)

If applicable, Standard PALs have a lower copayment than Premium PALs.

In order to support each practitioner's professional judgement in providing the ideal progressive lens design for an individual patient's needs, Davis Vision has implemented a 2-tier progressive lens formulary for many groups. Under the formulary, members may receive either Standard or Premium progressive lens designs. The patient charge for either category differs and is indicated on the group specified Service Record Form or Personalized Service Record Form. If there is no plan copayment, the formularies for Standard and Premium are combined. The provider reimbursement, or additional dispensing fee (surfee), is usually $30.00 for either category of progressive lenses. A listing of all progressive lens designs in each category is represented in the following table.

Please note: If your patient cannot successfully adapt to progressive lenses within 60 days, standard bifocals will be remade without any cost to the member. However, copayments or patient charges (if any) will not be refunded to the patient.

STANDARD LENSES

AO B Active
AO Compact
AO Compact Ultra
AO Pro 15
AO Pro 16
AO Technica
AO Tru Vision
Armorlite Elegance
Armorlite Navigator
Armorlite Navigator Short
Hoya GP Progressive
KbCo Fusion II
Essilor Adaptar
Essilor Decentered Adaptar
Essilor Super Noline
Sola VIP
Sola Decentered VIP
Sola VIP GOLD
Sola XL
Sola XL GOLD
Vision Ease Outlook
Vision Ease Premier
Vision Ease Tegra-Outlook
Vision Ease Varivue
X-cel Freedom ID
X-cel Freedom Fashion Fit
Younger Image

PREMIUM LENSES

AO Easy Progressive
Armorlite Kodak
Armorlite Kodak Concise
Armorlite Kodak Precise
Essilor Natural
Essilor Ovation
Essilor Ovation Smallfit
Hoya GP Wide
Hoya Summit CD
Hoya Summit ECP
Optima Hyperview
Pentax AF
Pentax AF Mini
Seiko Proceed
Seiko Proceed II
Sola Percepta
Sola Solamax
Sola SolaOne
Sola Visuality
Varilux Comfort
Varilux Ellipse
Varilux Liberty
Varilux Panamic
Varilux Physio
Zeiss Gradal Brevity
Zeiss Gradal HS
Zeiss Gradal Top
Zeiss GT2

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Anti-Reflective Coating (ARC)

The 3 categories are Standard, Premium, and Ultra. Standard being the lowest copayment, Premium next, then Ultra being at the highest copayment. The patient charge, provider reimbursement, or additional dispensing fee (surfee) for any of the category differs and is indicated on the group specified Service Record Form or Personalized Service Record Form, and the plan outline.

The below table indicates the various AR coatings included in each category.

STANDARD ARC

Standard AEGIS
Carl Zeiss BLUE (Super) ET
Carl Zeiss GOLD ET
Essilor REFLECTION FREE

PREMIUM ARC

Essilor CRIZAL
Carl Zeiss CARAT BLUE
Carl Zeiss CARAT GOLD

ULTRA ARC

Essilor ALIZE
Carl Zeiss CARAT ADVANTAGE BLUE
Carl Zeiss CARAT ADVANTAGE GOLD
Carl Zeiss TEFLON

CONTACT INFORMATION

If you need additional information, you may inquire by telephone or in writing to the following sources:

ADDRESS	INFORMATION	TELEPHONE NUMBER
Vision Care Claims Unit P.O. Box 1501 Latham, NY 12110	• Voucher submission • Payment	1-800-77- DAVIS
Vision Care Claims Unit P.O. Box 1501 Latham, NY 12110	For authorization and eligibility information • Eligibility • Benefits • Expired vouchers	1-800-77-DAVIS www.davisvision.com
Davis Vision 159 Express Street Plainview, NY 11803	• Central laboratory • Eyeglass orders • Ophthalmic materials	1-800-888-4321
Davis Vision Regional Laboratory: Renaissance Center 2340 E. Tropicana Avenue Las Vegas, NV 89119		1-800-393-7919
Davis Vision Regional Laboratory: Philadelphia Airport Business Center 7821 Bartram Avenue Philadelphia, PA 19153		1-800-836-2082
Davis Vision Regional Laboratory: 1665 Shelby Oaks Drive Suite 109 Memphis, TN 38134		1-888-573-2847
Davis Vision Regional Laboratory 520 Airport Road N.W. Suite A-5 Albuquerque, NM 87121		1-888-235-6633

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RECORD FORM

** Your Member Identification No. is the number by which the company that sponsors your vision care benefits identifies you.*

SECTION 1 - PROVIDER/PATIENT SECTION

Employee Name: _____ Employee Identification No.* _____

Patient Name: _____ Patient Birth Date: _____ Relationship to Employee: Self ____ Spouse _____ Child _____

Provider Name: _____ Provider No.: _____

Authorization No.: _____ Authorization Date: _____

SECTION 2A - SERVICE SECTION (Complete all applicable sections)

A. Examination: Yes _____ No _____ Primary Diagnosis code (required): _____ Secondary Diagnosis code (if any): _____

1. Was this a new patient? Yes _____ No _____
2. Was a comprehensive exam performed? Yes _____ No _____
3. Was dilation performed? Yes _____ No _____

B. Spectacle Lenses Supplied: Plan _____ Provider's _____

Single Vision _____ Bifocal _____ Trifocal _____ Aphakic _____

C. Frame Supplied: Plan _____ (Complete Section 2B) Patient's _____ Provider's _____ Retail Value $ _____

D. Contact Lenses Supplied: Provider's _____ Retail Value $ _____

SECTION 2B - PLAN FRAME ORDER SECTION

MFG.	FRAME NAME	EYE	BRIDGE	TEMPLE	COLOR

SECTION 2B - OPTIONS SECTION (Please check all items selected)

☑	Option	Letter
☐	Premier Frame	F
☐	Standard ARC (anti-reflective coating)	R
☐	Premium ARC (anti-reflective coating)	W
☐	Polarized Lenses	G
☐	Plastic Photosensitive Lenses	Q
☐	Oversized (57mm & up) Lenses	>
☐	Tint (Plastic Lenses) Solid	+
☐	Tint (Plastic Lenses) Gradient	T
☐	Tint (Glass Lenses) Solid	-
☐	Tint (Glass Lenses) Gradient	#
☐	Photogrey Extra® Lenses	P
☐	Blended Invisible Bifocal	E
☐	Standard Progressive Addition Lenses	I
☐	Premium Progressive Addition Lenses	@

☑	Option	Letter
☐ ☐	High Index Lenses (Glass) <1.6 index >=1.6 index	{ J
☐ ☐	High Index Lenses (Plastic) <1.6 index >=1.6 index	< H
☐	Mirror Coating	M
☐	Scratch-Resistant Coating	S
☐	Edge Treatment	V
☐	Polycarbonate Lenses	A
☐	Blended Myodisc	Y
☐	Quadrifocal Lenses	%
☐	Double Segment Lenses	B
☐	Ultraviolet Coating	U
☐	Executive Multifocal	=
☐	Intermediate Vision Lenses	$
☐	Low Power Aspheric Lenses	X

Service Date: _____ Patient Signature: _____

INSTRUCTIONS

1. This form should be maintained in your office for a period of at least three (3) years.
2. Completed forms should be faxed to Davis Vision at 1-888-328-4761 for processing and ordering of Davis Vision supplied frames (as applicable).

DAVIS VISION™
THE EYECARE ADVANTAGE

Dear Member Doctor and Staff:

As part of our continuous commitment to develop systems which will benefit your office and maximize productivity, Davis Vision is very pleased to provide you with this information about our enhanced Interactive Voice Response (IVR) Unit.

By simply calling our dedicated Provider Service number at 1-800-77-DAVIS (1-800-773-2847), you will **quickly and easily** be able to:

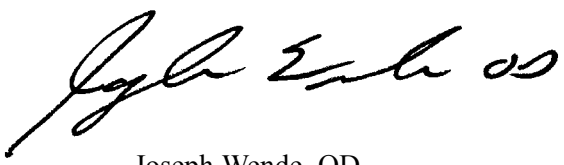
- receive expanded benefit entitlement information for all Davis Vision patients, including examination copayments or the "next date of eligibility" for currently ineligible patients
- receive authorization numbers for multiple family members and information for previously issued authorization number(s)
- have a personalized service record form faxed to your office, for most groups
- void and/or extend authorizations
- process claims for "eye examinations **only**" services without having to speak with a Provider Service Representative
- request additional supplies of service record forms, fee verification forms, or prior approval forms for medically necessary services
- inquire on previously submitted claims

Please have your Davis Vision Provider Number available when calling IVR at **1-800-77-DAVIS (1-800-773-2847)**

We understand and appreciate the value of your time, and have developed an easy-to-follow menu of instructions for using our IVR. Detailed information about the IVR's available options is included on the reverse side of this letter.

Thank you for your participation in our programs. We are certain the IVR's accessibility and easy to use features will be greatly beneficial to you.

Sincerely,



Joseph Wende, OD
Vice President
Professional Affairs

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Interactive Voice Response Unit

Available Options

1 - Another service, same patient
2 - Another patient, same family
3 - Services for different family
∗ - Main menu
9 - End call
0 - Transfer to a PSR
(Provider Service Representative)

PROVIDER PLACES CALL TO 1-800-77DAVIS

- Enter Davis Vision provider number, followed by the # sign
- Select Option 1,2,or 3

1 All Patient Services

- Enter Member ID number followed by the # sign
- Verify family name
- Select relationship
- Verify patient name
- Select option **1,2,3 or 4**

2 Order Service Record Forms / Info about PSRF

IVR states:
- To order press 1
- To get information on PSRF press 2

To place order in voice mail:
- State provider number
- State form number printed (on bottom right hand corner) and the name of group(s) for which forms are needed
- When ordering is completed, press "04702" to return to IVR, or disconnect

3 Info Web Site

Info about our website:
- Set up a password
- Speak with a representative
- Return to the main menu
- Hear message again

1 All Authorization Services

Select 1,2,3 or 4

1 Request a New Authorization

IVR states "Authorization has been issued" and:
- Offers PSRF if applicable
- Patient name
- Current benefit/eligibility
- "Authorization number is. . ."
- Exam copayment (if applicable)
- Repeat information if requested
- Select next option

2 Repeat an Existing Authorization

IVR states:
- Offers PSRF if applicable
- Authorization number is. . .
- Date issued
- Patient name
- Current benefit/eligibility
- Repeat information if requested
- Select next option

3 Extend an Existing Authorization

IVR states if paperless group:
The expiration date has been extended to (date)

OR

IVR states if voucher group:
- The expiration date has been extended. An extension card will be mailed to the member.
- Select next option

4 Void an Existing Authorization

IVR states:
"This authorization has been marked void."
- Select next option.

2 Eligibility Information

Current Eligibility

IVR states
(if previously authorized):
- "Authorization number is. . ."
- Date issued
- Patient name
- Current benefit/eligibility

or

IVR states
(if no previous authorization):
- Current benefit/eligibility

or

IVR states
(if ineligible):
- Next date of eligibility
- Repeat information if requested
- Select next option

3 Submission of Claim (Examination Only)

- Enter the date of service followed by # sign in Month ___ Date ___ Year (4-digit) ___ format
- Verify date of service
- Enter if new or established patient
- Enter if intermediate or comprehensive exam
- Enter whether dilation was or was not provided
- Verify procedure code
- Enter diagnostic code
- Verify diagnostic code
- IVR states: "Payment processed successfully" and gives out invoice number.
- Repeat information if requested
- Select next option

4 Claim Inquiry

IVR states:
- Date paid
- Authorization Number
- Date of service
- Invoice number
- Register date (if applicable)
- Check number (if applicable)
- Services and options submitted
- Total payments
- Break down exam and materials payments
- Press #1 to repeat
- Press #2 for next claim for same person
- Press #3 to check a claim for another family member
- Press ∗ key to return to main menu

Davis Vision
Provider Procedure Codes

Procedure Code	Description
CL01	Contact Lens Evaluation
CL02	Contact Lens Evaluation; Fitting (New Patient)
CL03	Contact Lens Evaluation; Re-Fit (Existing Wearer)
CL04	Contact Lens Evaluation; Fitting Toric (New Patient)
CL05	Contact Lens Evaluation; Re-Fit Toric (Existing Wearer)
CL12	Daily Wear Contact Lens Fitting (New Wearer)
CL13	Daily Wear Contact Lens Re-Fitting (Existing Wearer)
CL14	Toric Daily Wear Contact Lens Fitting (New Wearer)
CL15	Toric Daily Wear Contact Lens Re-Fitting (Existing Wearer)
CL16	Disposable Contact Lens Fitting (New Wearer)
CL17	Disposable Contact Lens Re-Fitting (Existing Wearer)
CL18	Toric Disposable Contact Lens Fitting (New Wearer)
CL19	Toric Disposable Contact Lens Re-Fitting (Existing Wearer)
92310	Daily Wear Contact Lens Fitting
S0592	Extended Wear Contact Lens Fitting
001	Examination Only
002	Exam, Plan SV, Plan Frame
003	Exam, Plan SV, Prac Frame
004	Exam, Plan SV, Own Frame
005	Exam, Plan BI, Plan Frame
006	Exam, Plan BI, Prac Frame
007	Exam, Plan BI, Own Frame
008	Exam, Plan TRI, Plan Frame
009	Exam, Plan TRI, Prac Frame
010	Exam, Plan TRI, Own Frame
011	Exam, Prac SV, Plan Frame
012	Exam, Prac BI, Plan Frame
013	Exam, Prac TRI, Plan Frame
014	Exam, Prac Aphakic SV, Plan Frame
015	Exam, Prac Aphakic BI, Plan Frame
016	Exam, Prac SV, Prac Frame
017	Exam, Prac BI, Prac Frame
018	Exam, Prac TRI, Prac Frame
019	Exam, Prac Aphakic SV, Prac Frame
020	Exam, Prac Aphakic BI, Prac Frame
021	Exam, Prac Contact Lenses
022	Exam, Prac Medically Necessary Contacts
023	Exam, Plan Contact Lenses
024	Exam, Plan Frame
029	Exam, Practioners Frame
030	Exam, Plan Disposable Contact Lenses
031	Exam, Plan Premium Disposable Contact Lenses
032	Exam, Plan SV Safety Complete
034	Exam, Plan SV Safety Lenses
035	Exam, Plan BI Safety Complete
037	Exam, Plan BI Safety Lenses

038	Exam, Plan Tri Safety Complete
039	Exam, Plan Tri Safety Lenses
N02	Plan SV, Plan Frame
N03	Plan SV, Prac Frame
N04	Plan SV, Own Frame
N05	Plan BI, Plan Frame
N06	Plan BI, Prac Frame
N07	Plan BI, Own Frame
N08	Plan TRI, Plan Frame
N09	Plan TRI, Prac Frame
N10	Plan TRI, Own Frame
N11	Prac SV, Plan Frame
N12	Prac BI, Plan Frame
N13	Prac TRI, Plan Frame
N14	Prac Aphakic SV, Plan Frame
N15	Prac Aphakic BI, Plan Frame
N16	Prac SV, Prac Frame
N17	Prac BI, Prac Frame
N18	Prac TRI, Prac Frame
N19	Prac Aphakic SV, Prac Frame
N20	Prac Aphakic BI, Prac Frame
N21	Prac Contact Lenses
N22	Prac Medically Necessary Contact Lenses
N23	Plan Contact Lenses
N24	Plan Frame, Member Lenses
N29	Practioners Frame
N30	Plan Disposable Contact Lenses
N31	Plan Premium Disposable Contact Lenses
N32	Safety SV, Safety Frame
N34	Safety SV, Own Frame
N35	Safety BI, Safety Frame
N37	Safety BI, Own Frame
N38	Safety TRI, Safety Frame
N39	Safety TRI, Own Frame
MN11	Prac SV, Own Frame
MN12	Prac BI, Own Frame
MN13	Prac TRI, Own Frame
MN14	Prac Aphakic SV, Own Frame
MN15	Prac Aphakic BI, Own Frame
M011	Exam, Prac SV, Own Frame
M012	Exam, Prac BI, Own Frame
M013	Exam, Prac TRI, Own Frame
M014	Exam, Prac Aphakic SV, Own Frame
M015	Exam, Prac Aphakic BI, Own Frame
R01	Refractive Exam Only
R02	Refractive Exam, Plan SV, Plan Frame
R03	Refractive Exam, Plan SV, Prac Frame
R04	Refractive Exam, Plan SV, Own Frame
R05	Refractive Exam, Plan BI, Plan Frame
R06	Refractive Exam, Plan BI, Prac Frame
R07	Refractive Exam, Plan BI, Own Frame

R08	Refractive Exam, Plan TRI, Plan Frame
R09	Refractive Exam, Plan TRI, Prac Frame
R10	Refractive Exam, Plan TRI, Own Frame
R11	Refractive Exam, Prac SV, Plan Frame
R12	Refractive Exam, Prac BI, Plan Frame
R13	Refractive Exam, Prac TRI, Plan Frame
R14	Refractive Exam, Prac Aphakic SV, Plan Frame
R15	Refractive Exam, Prac Aphakic BI, Plan Frame
R16	Refractive Exam, Prac SV, Prac Frame
R17	Refractive Exam, Prac BI, Prac Frame
R18	Refractive Exam, Prac TRI, Prac Frame
R19	Refractive Exam, Prac Aphakic SV, Prac Frame
R20	Refractive Exam, Prac Aphakic BI, Prac Frame
R21	Refractive Exam, Prac Contact Lenses
R22	Refractive Exam, Medically Necessary Contact Lenses
R23	Refractive Exam, Plan Contact Lenses
R24	Refractive Exam, Plan Frame
R29	Refractive Exam, Practioners Frame
R30	Refractive Exam, Plan Disposable Contact Lenses
R31	Refractive Exam, Plan Premium Disposable Contact Lenses
R32	Refractive Exam, Safety SV, Safety Frame
R34	Refractive Exam, Safety SV, Own Frame
R35	Refractive Exam, Safety BI, Safety Frame
R37	Refractive Exam, Safety BI, Own Frame
R38	Refractive Exam, Safety TRI, Safety Frame
R39	Refractive Exam, Safety TRI, Own Frame
S0500	Exam, Non Plan Disposable Contacts
SN500	Non Plan Disposable Contacts
E2500	Exam, Plan (Dr Supplied) Hard Contacts
N2500	Plan (Dr Supplied) Hard Contacts
NONS0500	Exam, Non Plan, Non Disposable Contacts
NONSN500	Non Plan Non Disposable Contacts

SV = Single Vision Lenses
BI = Bifocal Lenses
TRI = Trifocal Lenses

Davis Vision
Option Codes

F	Premier Frame
D	Designer/Metal Frames
L	Fashion Frame
S	Scratch Resistant Coating
P	Photogrey (PGX)
R	Anti Reflective Coating (standard)
U	Ultraviolet Coating
I	Standard Progressive Lenses
@	Premium Progressive Lenses
A	Polycarbonate Lenses
B	Double Segment Bifocals
E	Blended Invisible Bifocals
G	Polarized Lenses
H	High Index Plastic Lenses
T	Tinting (Plastic Gradient)
Q	Plastic Photosensitive Lenses
C	Color Coating
V	Edge Treatment
$	Intermediate Lenses
Y	Blended Myodisc
%	Quadrifocals
J	High Index Glass
M	Mirror Coating
K	Didymium Single Vision Lenses
O	Rose Tint (plastic)
N	Didymium Multifocal Lenses
W	Premium Anti Reflective Coating
Z	Ultra Anti Reflective Coating
+	Tinting (plastic solid)
-	Tinting (Glass)
=	Executive Multifocal
*	Rose Tint (glass)
#	Colorcoating (gradient)
<	High Index Plastic (under 1.6 center)
(	High Index Glass (under 1.6 center)
>	Oversize Lenses

DAVIS VISION™
THE EYECARE ADVANTAGE

VOUCHER/CLAIM FORM

VOUCHER NUMBER	
MEMBER ID #	
PATIENT NAME	
DATE OF BIRTH	
RELATIONSHIP TO MEMBER	_____ SELF _____ CHILD _____ SPOUSE
VOUCHER ISSUE DATE	
EXPIRATION DATE *	

ISSUED TO:

EXAM C0PAY	FRAMES			LENSES						CONTACTS		MULT PAIRS	OCC PLAN	OTHER
	SELECTION	COPAY	Non Plan Allow	CATG	COPAY AMOUNTS CLEAR	PGX	Prog. Lens	Plano Suns	Non Plan Allow	Plan Copay	Non Plan Allow			
	STAND SUPP DES-METAL PREMIER			SV BI TRI										

Please Note: 1. NA = Not Available

PART 1 **PROVIDER'S INFORMATION**

Please place check mark next to services provided, and enter amount paid to nearest dollar.

	Service	Please Check	Charges
1	Eye Examination	☐	$
2	Frames	☐	$
3	Single Vision Lenses	☐	$
4	Bifocal Lenses	☐	$
5	Trifocal Lenses	☐	$
6	Contact Lenses	☐	$
7	Cataract S. V. Lenses	☐	$
8	Cataract Bifocal Lenses	☐	$
9	Cataract Contact Lenses	☐	$
	TOTAL	☐	$

PART 2 **Please complete appropriate section**

EXAMINER

Name _____
Address _____
License # _____ Phone # _____
Date of Service _____ MO / DAY / YR
Signature _____

DISPENSER (If different from above)

Name _____
Address _____
License # _____ Phone # _____
Date of Service _____ MO / DAY / YR
Signature _____

PART 3

MEMBER/PATIENT SIGNATURE..... **DATE** .....

FOR PANEL DOCTOR'S AND CLAIMS PROCESSING UNIT USE ONLY

Provider's Name_____ Provider's #_____

Service Codes #1_____ #2 _____ #3 _____ Service Date ____ / ____ / ____ (MO / DAY / YR) Invoice # _____

Provider's Signature _____

PATIENT INSTRUCTIONS

Note: Services must be provided by this date.
Please note the VOUCHER EXPIRATION DATE.
EXTENSIONS may be obtained by calling 1-800-999-5431.

1. Be sure to present this form at the time of your appointment.
2. When you go to a network provider, sign Part 3 after services are rendered and leave this form with the provider. All services must be received at the same time since partial usage of the benefit will be considered the same as full usage. Utilizing one of the network providers generally provides you the most value from this benefit.
3. If you go to an out-of-network provider and/or optician, have Parts 1 and 2 completed by the provider when services are rendered. Sign Part 3 and submit top portion to the address below. All services must be claimed at the same time, since only one claim may be submitted during each benefit period. Retain bottom portion for your records.
4. The benefit may not be split between a network and an out-of-network provider.
5. Occupational (VDT) benefit (where applicable) is available at a network provider only.
6. Return unused vouchers to the address **below. Failure to do so may delay your receiving future benefits.

NETWORK PROVIDER'S/BENEFICIARY CLAIM COPY

ISSUED TO:

EXAM RECEIVED: ____ / ____ / ____ (MO DAY YR) AMOUNT $ _____

EYEWEAR RECEIVED: ____ / ____ / ____ (MO DAY YR) AMOUNT $ _____

VOUCHER NUMBER	
MEMBER ID #	
PATIENT NAME	
DATE OF BIRTH	
VOUCHER ISSUE DATE	
EXPIRATION DATE*	

FOR NETWORK PROVIDER'S USE ONLY

Service Codes #1 _____ #2 _____ #3 _____ Service Date ____ / ____ / ____ Invoice # _____

Provider # _____

**** Vision Care Processing Unit**
PO Box 1501
Latham, NY 12110

SHIP-BACK INFORMATION
TO ACCOMPANY ITEMS SENT TO LABORATORY
DAVIS VISION

520 Airport Road
Suite A-5
Albuquerque, NM 87121
(FAX) 1-505-833-3520

159 Express Street
Plainview NY 11803
1-800-888-4321
(FAX) 1-800-933-9375

7821 Bartram Avenue
Philadelphia, PA 19153
1-800-836-2082
(FAX) 215-937-0649

Renaissance Center
2340 E. Tropicana Avenue
Las Vegas, NV 89119
1-800-393-7919
(FAX) 1-702-270-7805

1665 Shelby Oakes Drive
Suite 109
Memphis, TN 38134
1-888-573-2847
(FAX) 901-213-3482

TODAY'S DATE

FROM:

DOCTOR'S NAME	PANEL #

PATIENT:

PATIENT'S NAME	VOUCHER #

FOR NON-PLAN FRAME ORDERS

FROM:

MANUFACTURER	STYLE	SIZE

REFERENCE:

DATE OF ORDER	INVOICE#	COLOR

FOR EYEGLASS RETURNS

ORIGINAL ORDER DATE:

DATE OF ORDER

INVOICE#

TYPE RETURNED (check one)

UNDISPENSED	
DISPENSED	
WARRANTY	

DETAILS: **PLEASE DESCRIBE REASONS FOR RETURN OF EYEWEAR BELOW:**

(FOR LABORATORY USE ONLY)

SHIP-BACK INFORMATION
TO ACCOMPANY ITEMS SENT TO LABORATORY
DAVIS VISION

520 Airport Road
Suite A-5
Albuquerque, NM 87121
(FAX) 1-505-833-3520

159 Express Street
Plainview NY 11803
1-800-888-4321
(FAX) 1-800-933-9375

7821 Bartram Avenue
Philadelphia, PA 19153
1-800-836-2082
(FAX) 215-937-0649

Renaissance Center
2340 E. Tropicana Avenue
Las Vegas, NV 89119
1-800-393-7919
(FAX) 1-702-270-7805

1665 Shelby Oakes Drive
Suite 109
Memphis, TN 38134
1-888-573-2847
(FAX) 901-213-3482

TODAY'S DATE

FROM: DOCTOR'S NAME | PANEL #

PATIENT: PATIENT'S NAME | VOUCHER #

FOR NON-PLAN FRAME ORDERS

FROM: MANUFACTURER | STYLE | SIZE

REFERENCE: DATE OF ORDER | INVOICE# | COLOR

FOR EYEGLASS RETURNS

ORIGINAL ORDER DATE: DATE OF ORDER

INVOICE#

TYPE RETURNED (check one)

UNDISPENSED
DISPENSED
WARRANTY

DETAILS: **PLEASE DESCRIBE REASONS FOR RETURN OF EYEWEAR BELOW:**

(FOR LABORATORY USE ONLY)

MS00176-3/29/05

DAVIS VISION
THE EYECARE ADVANTAGE
www.davisvision.com

FAX LABORATORY ORDER FORM

PANEL #: _____ PRACTITIONER IDENTIFIER: _____

SERVICING PRACTITiONER NAME: _____

AUTHORIZATION #: _____ MEMBER ID#: _____

PATIENT NAME _____ PANEL FAX # _____

Pair # (1= 1st pair, etc.): _____ **TYPE:** Dress ☐ VDT ☐ Safety ☐ Occupational ☐ Date of Service _____

TYPE: REDO ☐ Redo Reason: _____ EXCEL ADVANTAGE ☐

SERVICES:

Examination: Yes ☐ No ☐

Contact lens evaluation and fitting: Yes ☐ No ☐

If yes: Daily Wear ☐ or Extended Wear ☐

Is this an occupational/VDT exam*: Yes ☐ No ☐

*Only applicable for specific groups; please refer to group specific plan outline.

The information below is required to process an exam order.

Is this a new patient? Yes ☐ No ☐

Did you provide a comprehensive exam? Yes ☐ No ☐

Dilation: Yes ☐ No ☐

Primary Diagnosis (ICD-9) Code (**required**): _____

Secondary Diagnosis Code (if any): _____

LENS MATERIALS:

Plastic ☐ High Index ☐ (Specify Index: _____)

Plastic Photosensitive ☐ GRY ___ BRN ___ XTR ___ TYPE _____

Polycarbonate ☐ (No charge for dependent children, monocular patients and/or prescriptions +/- 6 diopters or greater.)

Glass ☐ PGX ___ PBX ___ CLR ___

Other ☐ (Specify Other: _____)

LENS COATINGS:

UV ☐ ARC ☐ TYPE _____

SCRATCH-RESISTANT COATING ☐

COLOR OF TINT	PERCENTAGE	SOLID ☐
		GRADIENT ☐

SPECIAL INSTRUCTIONS:

PRESCRIPTION INFORMATION:

	SPHERE	CYLINDER	AXIS	PD/DIST	PD/NEAR	PRISM	BASE
R:							
L:							

PD:

BINOCULAR ☐

MONOCULAR ☐

MULTIFOCAL SPECIFICATIONS: (NOTE: PLEASE ALWAYS SPECIFY LENS TYPE, I.E., STRAIGHT TOP 35, VARLUX COMFORT.)

	TYPE	ADD	SEG HEIGHT	BASE CURVE	OC HEIGHT
R:					
L:					

FRAME:

MFG	FRAME NAME	EYE	BRIDGE	TEMPLE	COLOR	FRAME TYPE
						Plan ☐ Non-Plan ☐ (complete Non-Plan frame info below)

NON-PLAN FRAMES:

Patient's Own ☐ Provider Supplied ☐ Frame Cost $ _____ (Retail Cost ☐) (Wholesale Cost ☐)

Frame to follow YES ☐ NO ☐ Grooved Rimless ☐ Full ☐ Drilled: 2 Hole ☐ 4 Hole ☐

IF NO: A _____ B _____ ED _____ CIRC _____

NON-PLAN LENSES / CONTACT LENSES:

Patient's Own ☐ Provider Supplied ☐ Hard ☐

Type: SV ☐ BI ☐ TRI ☐ Contacts ☐ Disposable ☐

Lens Cost $_____(Retail Cost) Non-Disposable ☐

CONTACT LENSES: NEW WEARER ☐ EXISTING WEARER ☐ (Plan Supplied)

Manufacturer: _____ Series: _____

Number of boxes per eye:_____ (if applicable, see provider outline)

	SPHERE	BASE	DIAMETER
R:			
L:			

If you have any questions or do not receive a fax confirmation within 24 hours, please contact:

Phone: 1-800-888-4321 Fax: 1-800-933-9375

You can also place orders online at www.davisvision.com

DAVIS VISION™
THE EYECARE ADVANTAGE

EXAM ONLY FAX SHEET

Panel#: _____

Panel Fax#: _____ Date: _____

***NOTE: If exam only services were provided (no material order), complete the information below. A separate FAX LAB ORDER FORM is not required for exam only patients.**

Fax to: 1-800-933-9375

	PATIENT NAME	AUTHORIZATION NUMBER	PRACTITIONER IDENTIFIER	DATE OF SERVICE	EXAM SERVICES		
					DILATION	CPT CODE	ICD-9 CODE
1					☐ YES ☐ NO	☐ 92002 ☐ 92012 ☐ 92004 ☐ 92014	☐ V72.0 ☐ _____
2					☐ YES ☐ NO	☐ 92002 ☐ 92012 ☐ 92004 ☐ 92014	☐ V72.0 ☐ _____
3					☐ YES ☐ NO	☐ 92002 ☐ 92012 ☐ 92004 ☐ 92014	☐ V72.0 ☐ _____
4					☐ YES ☐ NO	☐ 92002 ☐ 92012 ☐ 92004 ☐ 92014	☐ V72.0 ☐ _____
5					☐ YES ☐ NO	☐ 92002 ☐ 92012 ☐ 92004 ☐ 92014	☐ V72.0 ☐ _____
6					☐ YES ☐ NO	☐ 92002 ☐ 92012 ☐ 92004 ☐ 92014	☐ V72.0 ☐ _____
7					☐ YES ☐ NO	☐ 92002 ☐ 92012 ☐ 92004 ☐ 92014	☐ V72.0 ☐ _____
8					☐ YES ☐ NO	☐ 92002 ☐ 92012 ☐ 92004 ☐ 92014	☐ V72.0 ☐ _____
9					☐ YES ☐ NO	☐ 92002 ☐ 92012 ☐ 92004 ☐ 92014	☐ V72.0 ☐ _____
10					☐ YES ☐ NO	☐ 92002 ☐ 92012 ☐ 92004 ☐ 92014	☐ V72.0 ☐ _____
11					☐ YES ☐ NO	☐ 92002 ☐ 92012 ☐ 92004 ☐ 92014	☐ V72.0 ☐ _____
12					☐ YES ☐ NO	☐ 92002 ☐ 92012 ☐ 92004 ☐ 92014	☐ V72.0 ☐ _____
13					☐ YES ☐ NO	☐ 92002 ☐ 92012 ☐ 92004 ☐ 92014	☐ V72.0 ☐ _____
14					☐ YES ☐ NO	☐ 92002 ☐ 92012 ☐ 92004 ☐ 92014	☐ V72.0 ☐ _____
15					☐ YES ☐ NO	☐ 92002 ☐ 92012 ☐ 92004 ☐ 92014	☐ V72.0 ☐ _____
16					☐ YES ☐ NO	☐ 92002 ☐ 92012 ☐ 92004 ☐ 92014	☐ V72.0 ☐ _____
17					☐ YES ☐ NO	☐ 92002 ☐ 92012 ☐ 92004 ☐ 92014	☐ V72.0 ☐ _____
18					☐ YES ☐ NO	☐ 92002 ☐ 92012 ☐ 92004 ☐ 92014	☐ V72.0 ☐ _____

NOTE: If you do not receive a fax confirmation or a fax request for missing /unreadable information within 24 hours, please contact the number below and ask for a fax representative:
Phone: 1-800-888-4321 or Fax: 1-800-933-9375
or visit our website at www.davisvision.com

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www.davisvision.com

*Supplemental Credentials Warranty**

***All persons who provide services, which require a license, shall complete this form (i.e., MD, DO, OD)**

Please note: persons who provide an affirmative "Yes" response to any of the questions numbered 2-11 (inclusive), are required to also provide a factual, detailed explanation for each affirmative response on a separate sheet.

1. For each of the preceding years since you were last credentialed by Davis Vision, have you received a minimum of six (6) continuing education credits per year, or the minimum number of credits per year that are mandated by the state(s) in which you practice? ☐ Yes ☐ No
2. Have you been convicted of a felony or are you currently under indictment for a criminal offense? ☐ Yes ☐ No
3. Have any of your licenses been sanctioned, placed on probation, suspended or revoked in any state? ☐ Yes ☐ No
4. Have you been subject to any disciplinary action by any professional organization or any licensing authority? ☐ Yes ☐ No
5. Has your participation status in Medicare and/or Medicaid ever been modified, sanctioned, suspended or terminated? ☐ Yes ☐ No
6. Have you been subject to any loss or limitation of clinical privileges by any facility or organization with which you have had privileges? ☐ Yes ☐ No
7. Has any claim or suit alleging malpractice against you ever been filed, pended, appealed and/or settled by you or by your insurance carrier on your behalf? If any judgment(s) have been entered against you, please list and describe all judgments. ☐ Yes ☐ No
8. Has your malpractice (professional liability) insurance ever been restricted, special-rated, not renewed, suspended and/or cancelled? ☐ Yes ☐ No
9. Does your mental health status or physical health status ever effect or interfere with your ability to practice your profession or perform the duties permitted under your license? ☐ Yes ☐ No
10. Is your ability to practice your profession or to perform your duties under your license in any way impaired due to chemical or substance abuse? ☐ Yes ☐ No
11. Within the last five (5) years, have you ever been a panel provider in another network in which you currently no longer participate? If yes, and if you were suspended or terminated from panel participation, please provide an explanation on a separate sheet. ☐ Yes ☐ No

Please list the preceding five (5) years of your work history below, starting with the current year. Indicate the beginning month/year and ending month/year at each location listed. Please list any additional work history information on a separate sheet, using the same format below.

Address 1 (Required)	Month/Year (Required) to Month/Year (Required)	Address 2 (If applicble)	Month/Year (If applicable) to Month Year (If applicable)
	to Present		to
	to		to
	to		to
	to		to
	to		to

Are Medical Records stored in a secure location within the office? ☐ Yes ☐ No
Is access to Medical Records restricted to authorized personnel? ☐ Yes ☐ No

The information on my original Davis Vision application contains detailed and specific information relating to my character and professional competence. I warrant that all information I have provided and the response I have given in this and all documents are correct and complete to the best of my knowledge and belief. I attest that within thirty (30) days of becoming aware of any suspension or termination of my participation privileges as a panel provider with any other health benefit plan, insurer, HMO, or third party administrator (including Medicare and Medicaid), I will notify Davis Vision in writing of such an occurrence. I further attest that within thirty (30) days of becoming aware of any malpractice action against me, I will notify Davis Vision in writing of such an occurrence. I understand that willful falsification of this information will be grounds for rejection or termination.

My signature here authorizes Davis Vision to verify the information I have provided with any Federal/State agency or any professional health or education organization.

_____ _____
Signature (Full Legal Name) Date

_____ _____
Print Name (Full Legal Name) Provider Number (or Numbers)

National Provider Identifier number (NPI#) _____

CREDENTIALING CHECKLIST - OPHTHALMOLOGY

PROVIDER NAME_____STATE_____

I. PROVIDER INFORMATION

OTHER PRACTICING STATES:_____ Exp:____/____/____

		DATE SIGNED/EXP DATE	COMMENTS
I. CURRENT NPDB QUERY		/ /	
a) NPDB Infractions	**___YES ___NO**		
II. PROFESSIONAL BACKGROUND		/ /	
a) Professional Employment History or CV			
b) No gaps in work history (past 5 yrs)			
c) Infractions History?	**___YES ___NO**	**If *Yes*, Comments Required:**	
III. CURRENT LICENSE		/ /	
IIIa. LICENSE VERIFICATIONS		/ /	
IV. CURRENT DEA CERTIFICATE		/ /	
V. CURRENT CSR (if applicable)		/ /	
VI. MEDICARE OPT-OUT		/ /	
VII. CURRENT INSURANCE		/ /	
VIII. REFRACTIVE SURGERY CERTIFICATION			
IX. HOSPITAL AFFILIATIONS (past 5 years)			
X. BOARD CERTIFICATION		/ /	
Xa. BOARD RECERTIFICATION DATE (if applicable)		/ /	
XI. RESIDENCY PROGRAM		/ /	
XII. SCHOOL VERIFICATION		/ /	
XII. PATIENT EXAM FORM			

COMMENTS _____

DOCTOR APPROVED FOR: _____ Vision Care Only _____ Refractive Surgery _____DECLINED

REASON FOR DENIAL_____

I, _____, attest that the documentation in this file is complete as of _____/_____/_____, and has been source verified as applicable.
Associate Signature

I, _____, attest that the documentation has been reviewed as of _____/_____/_____, and is accurate and complete.
Associate Signature

NAME	**SIGNED**	**DATE**
COMMITTEE MEMBER:_____	_____	_____/_____/_____
COMMITTEE MEMBER:_____	_____	_____/_____/_____

II. OFFICE INFORMATION

PANEL # (S)					
I. APPLICATION					
a) Practice Information Complete					
b) Minimum of 12 office hrs/week					
c) All Required Equipment Including					
II. LETTER OF AGREEMENT					
ACTIVE					
INACTIVE					

Revised 11/04

CREDENTIALING CHECKLIST - OPTOMETRY

PROVIDER NAME_____STATE_____

I. PROVIDER INFORMATION

OTHER PRACTICING STATES: _____ Exp: / /

		DATE SIGNED/EXP DATE	COMMENTS
I. CURRENT NPDB QUERY		/ /	
a) NPDB Infraction	**___YES ___NO**		
II. PROFESSIONAL BACKGROUND		/ /	
a) Professional Employment History or CV attached			
b) No gaps in work history (past 5 yrs)			
c) Infractions History?	**___YES ___NO**	**If *Yes*, Comments Required:**	
III. CURRENT LICENSE		/ /	
IIIa. LICENSE VERIFICATIONS		/ /	
a) DPA			
b) TPA			
IV. MEDICARE OPT-OUT		/ /	
V. CURRENT INSURANCE		/ /	
VI. SCHOOL VERIFICATION		/ /	
VII. PATIENT EXAM FORM			

COMMENTS _____

DOCTOR APPROVED FOR: _____ DPA _____TPA _____DECLINED

REASON FOR DENIAL _____

_____

I, _____, attest that the documentation in this file is complete as of _____/_____/_____, and has been source verified as applicable.
Associate Signature

I, _____, attest that the documentation has been reviewed as of _____/_____/_____, and is accurate and complete.
Associate Signature

NAME	**SIGNED**	**DATE**
COMMITTEE MEMBER: _____	_____	_____/_____/_____
COMMITTEE MEMBER: _____	_____	_____/_____/_____

II. OFFICE INFORMATION

PANEL # (S)					
I. APPLICATION					
a) Practice Information Complete					
b) Minimum of 12 office hrs/week					
c) All Required Equipment Including					
1) Biomicroscope (Slit Lamp)					
2) Binocular Indirect Oph. (B.I.O.)					
II. LETTER OF AGREEMENT					
ACTIVE					
INACTIVE					

RECREDENTIALING CHECKLIST – OPHTHALMOLOGY

PROVIDER NAME_____STATE_____CREDENTIALED_____

I. PROVIDER INFORMATION OTHER PRACTICING STATES: _____ Exp: / /

I. CURRENT NPDB QUERY		/ /	
a) NPDB Infractions	**___YES ___NO**		
II. SUPPLEMENTAL WARRANTY		/ /	
a) Professional Employment History or CV			
b) No gaps in work history (past 5 yrs)			
c) Infractions History?	**___YES ___NO**	**If *Yes*, Comments Required:**	
III. CURRENT LICENSE		/ /	
IIIa. LICENSE VERIFICATIONS		/ /	
IV. CURRENT DEA CERTIFICATE		/ /	
V. CURRENT CSR (if applicable)		/ /	
VI. CURRENT INSURANCE		/ /	
VII. MEDICARE OPT-OUT		/ /	
VIII. HOSPITAL AFFILIATIONS (past 5 years)			
IX. BOARD CERTIFICATION		/ /	
IXa. BOARD RECERTIFICATION DATE (if applicable)		/ /	
X. RESIDENCY PROGRAM		/ /	
XI. SCHOOL VERIFICATION		/ /	
XII. PATIENT EXAM FORM			
XIII. SITE VISIT	**___YES ___NO**	/ /	
XIV. RECORD AUDIT	**___YES ___NO**	/ /	
XV. PATIENT COMPLAINT LOG	**___YES ___NO**		
XVI. PROVIDER SATISFACTION REPORT	**___YES ___NO**		

COMMENTS _____

DOCTOR APPROVED FOR: _____ Vision Care Only _____ Refractive Surgery _____DECLINED

REASON FOR DENIAL _____

_____

I, _____, attest that the documentation in this file is complete as of _____/_____/_____, and has been source verified as applicable.
Associate Signature

I, _____, attest that the documentation has been reviewed as of _____/_____/_____, and is accurate and complete.
Associate Signature

NAME	**SIGNED**	**DATE**
COMMITTEE MEMBER:_____	_____	_____/_____/_____
COMMITTEE MEMBER: _____	_____	_____/_____/_____

II. OFFICE INFORMATION

PANEL # (S)					
I. APPLICATION					
a) Practice Information Complete					
b) Minimum of 12 office hrs/week					
c) All Required Equipment					
II. LETTER OF AGREEMENT					
ACTIVE					
INACTIVE					

RECREDENTIALING CHECKLIST - OPTOMETRY

Provider Name_____State_____ Credentialed_____

I. PROVIDER INFORMATION

OTHER PRACTICING STATES: _____

		DATE SIGNED/EXP DATE	COMMENTS
I. CURRENT NPDB QUERY		/ /	
a) NPDB Infractions	___YES ___NO		
II. SUPPLEMENTAL WARRANTY		/ /	
a) Professional Employment History or CV			
b) No gaps in work history (past 5 yrs)			
c) Infractions History?	___YES ___NO	**If *Yes*, Comments Required:**	
III. CURRENT LICENSE		/ /	
IIIa. LICENSE VERIFICATIONS		/ /	
a) DPA			
b) TPA			
IV. MEDICARE OPT-OUT		/ /	
V. CURRENT INSURANCE		/ /	
VI. SCHOOL VERIFICATION		/ /	
VII. PATIENT EXAM FORM			
VIII. SITE VISIT	___YES ___NO	/ /	
IX. RECORD AUDIT	___YES ___NO	/ /	
X. PATIENT COMPLAINT LOG	___YES ___NO		
XI. PROVIDER SATISFACTION REPORT	___YES ___NO		

COMMENTS _____

_____

DOCTOR APPROVED FOR: _____DPA _____TPA _____DECLINED

REASON FOR DENIAL _____

I, _____, attest that the documentation in this file is complete as of _____/_____/_____, and has been source verified as applicable.
Associate Signature

I, _____, attest that the documentation has been reviewed as of _____/_____/_____, and is accurate and complete.
Associate Signature

NAME	**SIGNED**	**DATE**
COMMITTEE MEMBER: _____	_____	_____/_____/_____
COMMITTEE MEMBER: _____	_____	_____/_____/_____

II. OFFICE INFORMATION

PANEL # (S)					
I. APPLICATION					
a) Practice Information Complete					
b) Minimum of 12 office hrs/week					
c) All Required Equipment Including					
1) Biomicroscope (Slit Lamp)					
2) Binocular Indirect Oph. (B.I.O.)					
II. LETTER OF AGREEMENT					
ACTIVE					
INACTIVE					

Provider Name: **Provider Number:** DATE

RQAR:

PRINT NAME

	I Demographics (8)			II Case History (14)				III Habitual VA (4)		IV Eye Health (30)						V Refraction (20)					VI Binoc Function (8)				VII Assessment / Mgt (11)				VIII Other (5)		
Chart Identification	**Adult/Child/Special**	**Form (4)**	**Demographics (4)**	**CC (4)**	**EH (4)**	**MH (4)**	**FH (2)**	**Distance (2)**	**Near (2)**	**External (8)**	**Internal (8)**	**Visual Field (2)**	**Pupil (3)**	**Tonometry (4)**	**Dilation (5)**	**Objective (4)**	**Subjective (8)**	**Distance VA (2)**	**Near Refraction (4)**	**Near VA (2)**	**Ocular Motility (2)**	**NPC (2)**	**Near Phorias (2)**	**Distance Phorias (2)**	**Diagnosis (3)**	**Education (2)**	**Plan (3)**	**Assessment (3)**	**Dr. Signature (2)**	**Legibility (3)**	**TOTALS**
1.																															
2.																															
3.																															
4.																															
5.																															
6.																															
7.																															
8.																															
9.																															
10.																															
Numerical Totals	**X**																														**X**
Numerical average	**X**																														

Courtesy Letter		Observations & Comments:
Deficiency Letter		
Additional Records		
Call Reviewer		
Revisit Required		
Additional Comments on reverse side		

For Office Use Only:

Site Visit **I** **II** **III**

Record Review **I** **II** **III**

Reviewer's Signature

DAVIS VISION
THE EYECARE ADVANTAGE
www.davisvision.com

PROVIDER FACILITY REVIEW

Provider #: _____ Provider Name: _____ Date: _____

RQAR: _____ Address_____ City_____ State ___

I. Facility:

Evaluation

	Satisfactory	Unsatisfactory	Comments
A. *Reception & Waiting Area*			
Space and seating	☐	☐	_____
Cleanliness and Ventilation	☐	☐	_____
Handicap Access	☐	☐	_____
B. *Examining Rooms* (number _____)			
Space and optical distance	☐	☐	_____
Space and optical distance	☐	☐	_____
Cleanliness and Ventilation	☐	☐	_____
Handicap Access	☐	☐	_____
C. *Dispensing Area*			
Location of Davis Tower: _____ dispensary _____ other	☐	☐	_____
Space and Seating	☐	☐	_____
Cleanliness and Ventilation	☐	☐	_____
Handicap Access	☐	☐	_____
D. *Auxilliary Rooms* (number _____)			
Contact lens _____	☐	☐	_____
Pre-testing _____	☐	☐	_____
Visual fields _____	☐	☐	_____
Vision Training _____	☐	☐	_____
Laboraory _____	☐	☐	_____
Consultation Room _____	☐	☐	_____
Other (describe) _____			
Comments _____			
_____			

II. Personnel:

Appearance/Attitude

	Name Tag y	Name Tag n	Satisfactory	Unsatisfactory	Comments
A. *Optometrists (number _____)*					
Names: DV# _____	☐	☐	☐	☐	_____
DV# _____	☐	☐	☐	☐	_____
DV# _____	☐	☐	☐	☐	_____
B. *Ophthalmologists* (number _____)	y	n			
Names: DV# _____	☐	☐	☐	☐	_____
DV# _____	☐	☐	☐	☐	_____
DV# _____	☐	☐	☐	☐	_____
C. *Office personnel* (number _____)	y	n			
Office Manager: Name: _____	☐	☐	☐	☐	_____
Receptionist: Name: _____	☐	☐	☐	☐	_____
Additional: Name: _____	☐	☐	☐	☐	_____
D. *Dispensing* (number _____)	y	n			
Name: _____	☐	☐	☐	☐	_____
Name: _____	☐	☐	☐	☐	_____

III. Appointments:

Office Hours: **Mon**_____to_____ **Tue**_____to_____ **Wed**_____to_____ **Thur**_____to_____ **Fri**_____to_____

Sat_____to_____ **Sun**_____to_____ **Total Doctor hours**_____

Percent of Exams by appointment: _____% Percent of Exams by walk-in: _____%

	Satisfactory	Unsatisfactory	Comments
A. *Evidence of discrimination in appointments: (check appointment book)* NO ☐ YES ☐ If yes, explain: _____	☐	☐	_____
B. *Appointments confirmed:* NO ☐ YES ☐ (If yes, by phone ☐ by mail ☐)	☐	☐	_____
C. *Length of appointment:* _____minutes	☐	☐	_____

IV. Equipment:

	Adequate	Inadequate		Comments
		Absent	Poor	
Examination Chair	☐	☐	☐	
Instrument Stand	☐	☐	☐	
Projector Chart/Slides	☐	☐	☐	
Near Point Cards	☐	☐	☐	
Direct Ophthalmoscope	☐	☐	☐	
Binocular Indirect Ophthalmoscope	☐	☐	☐	
Retinoscope/Auto Refractor	☐	☐	☐	
Phoropter	☐	☐	☐	
Tonometer/Type	☐	☐	☐	
Trial Lens Set	☐	☐	☐	
Trial Frame	☐	☐	☐	
Lensometer	☐	☐	☐	
Keratometer	☐	☐	☐	
Biomicroscope	☐	☐	☐	
Central Field Test/Instrument	☐	☐	☐	
Contact Lens Kit	☐	☐	☐	
Perimeter	☐	☐	☐	
Color Vision Test	☐	☐	☐	
Other	☐	☐	☐	

V. Infection Control:

	Satisfactory	Unsatisfactory	Comments
A. Sink	☐	☐	_____
B. Pharmaceuticals and Solutions (expiration date)	☐	☐	_____
C. Contact Lenses (expiration date)	☐	☐	_____

VI. Dispensing Services:

A. Frames usually shown by: _____	☐	☐	_____
B. Eyeglasses usually dispensed by: _____	☐	☐	_____
C. Notification for pickup time:	☐	☐	_____
after exam ☐ telephoned ☐ mail notice ☐ patient calls ☐	☐	☐	_____
none ☐ other: _____	☐	☐	_____
pickup by appointment YES ☐ NO ☐	☐	☐	_____
D. Second notification for pickup time: YES ☐ NO ☐	☐	☐	_____

VII. Additional Services: YES ☐ NO ☐ (if YES please list)

_____

_____

VIII. Cooperation of Office Personnel (Doctor and staff)	☐	☐	_____

PRIVACY PRACTICES NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your medical information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your medical information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect April 14, 2006, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes, in our privacy practices and the new terms of our notice, effective for all medical information that we maintain, including medical information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and send the new notice to our vision care plan subscribers at the time of the change.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

Uses and Disclosures of Medical Information

We use and disclose medical information about you for treatment, payment, and health care operations. For example:

Treatment: We may use or disclose your medical information to a vision care or other health care provider in order to provide treatment to you.

Payment: We may use and disclose your medical information to pay claims from physicians, vision care providers and other providers for services delivered to you that are covered by your vision care plan, to determine your eligibility for benefits, to coordinate benefits, to examine medical necessity, to obtain premiums, to issue explanations of benefits to the person who subscribes to the vision care plan in which you participate, and the like. We may disclose your medical information to a health care provider or entity subject to the federal Privacy Rules so they can obtain payment or engage in these payment activities.

Health Care Operations: We may use and disclose your medical information in connection with our health care operations. Health care operations include:

- Rating our risk and determining our premiums for your vision care plan;
- Quality assessment and improvement activities;
- Reviewing the competence or qualifications of vision care professionals, evaluating vision care provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities;
- Medical review, legal services, and auditing, including fraud and abuse detection and compliance;
- Business planning and development; and
- Business management and general administrative activities, including management activities relating to privacy, customer service, resolution of internal grievances, and creating

de-identified medical information or a limited data set.

We may disclose your medical information to another entity which has a relationship with you and is subject to the federal Privacy Rules, for their health care operations relating to quality assessment and improvement activities, reviewing the competence or qualifications of vision care professionals, or detecting or preventing health care fraud and abuse.

On Your Authorization: You may give us written authorization to use your medical information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your medical information for any reason except those described in this notice.

Others Involved in Your Care: Unless you object, we may disclose your medical information to a family member, friend or other person to the extent necessary to help with your vision care or with payment for your vision care. We may use or disclose your name, location, and general condition or death to notify, or assist in the notification of (including identifying or locating), a person involved in your care.

Before we disclose your medical information to a person involved in your vision care or payment for your vision care, we will provide you with an opportunity to object to such uses or disclosures. If you are not present, or in the event of your incapacity or an emergency, we will disclose your medical information based on our professional judgment of whether the disclosure would be in your best interest.

Your Employer or Organization Sponsoring Your Group Health Plan: We may disclose your medical information and the medical information of others enrolled in your group health care plan to the employer or other organization that sponsors your group health care plan to permit the plan sponsor to perform plan administration functions. For example, we may disclose the minimum necessary vision care claims information to the employer or other organization that sponsors your vision benefit for the purposes of obtaining payment for vision care services you received. Your employer or other organization sponsoring your Group Health Plan may contact us on your behalf concerning benefits, claims, coverage, etc. and we will provide the minimum necessary information to respond to the inquiry. Please see your group health plan document for a full explanation of the limited uses and disclosures that the plan sponsor may make of your medical information in providing plan administration.

We may also disclose summary information about the enrollees in your group health plan to the plan sponsor to use to obtain premium bids for the vision care insurance coverage offered through your group health plan or to decide whether to modify, amend or terminate your group health plan. The summary information we may disclose summarizes claims history, claims expenses, or types of claims experienced by the enrollees in your group health plan. The summary information will be stripped of demographic information about the enrollees in the group health plan, but the plan sponsor may still be able to identify you or other enrollees in your group health plan from the summary information.

Underwriting: We may receive your medical information for underwriting, premium rating or other activities relating to the creation, renewal or replacement of a contract of vision care insurance or vision care benefits. We will not use or further disclose this medical information for any other purpose, except as required by law, unless the contract of vision care insurance or vision care benefits is placed with us. In that case, our use and disclosure of your medical information will only be as described in this notice.

Disaster Relief: We may use or disclose your medical information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

Public Benefit: We may use or disclose your medical information as authorized by law for the following purposes deemed to be in the public interest or benefit:

- As required by law;
- For public health activities, including disease and vital statistic reporting, child abuse reporting, FDA oversight, and to employers regarding work-related illness or injury;
- To report adult abuse, neglect, or domestic violence;
- To health oversight agencies;
- In response to court and administrative orders and other lawful processes;

- To law enforcement officials pursuant to subpoenas and other lawful processes, concerning crime victims, suspicious deaths, crimes on our premises, reporting crimes in emergencies, and for purposes of identifying or locating a suspect or other person;
- To coroners, medical examiners, and funeral directors;
- To organ procurement organizations;
- To avert a serious threat to health or safety;
- In connection with certain research activities;
- To the military and to federal officials for lawful intelligence, counterintelligence, and national security activities;
- To correctional institutions regarding inmates; and
- As authorized by state worker's compensation laws.

Health Related Services. We may use your medical information to contact you with information about vision care related benefits and services or about treatment alternatives that may be of interest to you. We may disclose your medical information to a business associate to assist us in these activities.

We may use or disclose your medical information to encourage you to purchase or use a product or service by face-to-face communication or to provide you with promotional gifts.

Individual Rights

Access: You have the right to look at or get copies of your medical information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your medical information. You may obtain a form to request access by using the contact information listed at the end of this notice or by visiting our website. You may also request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you a cost-based fee for staff time to locate and copy your medical information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your medical information in that format. If you prefer, we will prepare a summary or an explanation of your medical information for a fee. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your medical information for purposes other than treatment, payment, health care operations, as authorized by you, and for certain other activities, since April 14, 2003. You must make a request in writing to obtain an accounting of all disclosures of your medical information. You may obtain a form to request a disclosure accounting by using the contact information listed at the end of this notice or by visiting our website. We will provide you with the date on which we made the disclosure, the name of the person or entity to whom we disclosed your medical information, a description of the medical information we disclosed, the reason for the disclosure, and certain other information. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your medical information. You may obtain a form to request restrictions by using the contact information listed at the end of this notice or by visiting our website. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). Any agreement to additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. We will not be bound unless our agreement is so memorialized in writing.

Confidential Communication: You have the right to request that we communicate with you about your medical information by alternative means or to alternative locations. You must make your request in writing, and you must state that the information could endanger you if it is not communicated in confidence as you request. You may obtain a form to request confidential communications by using the contact information listed at the end of this notice or by visiting our website. We must accommodate your request if it is reasonable, specifies the alternative means or location, and continues to permit us to collect premiums and pay claims under your vision care plan, including issuance of explanations of

benefits to the subscriber of the vision care plan in which you participate. An explanation of benefits issued to the subscriber for vision care that you received for which you did not request confidential communications or about the subscriber or others covered by the vision care plan in which you participate may contain sufficient information to reveal that you obtained vision care for which we paid, even though you requested that we communicate with you about that vision care in confidence.

Amendment. You have the right to request that we amend your medical information. Your request must be in writing, and it must explain why the information should be amended. You may obtain a form to request an amendment by using the contact information listed at the end of this notice or by visiting our website. We may deny your request if we did not create the information you want amended and the originator remains available or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement to be appended to the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information.

Electronic Notice: If you receive this notice on our web site or by electronic mail (e-mail), you are entitled to receive this notice in written form. Please contact us using the information listed at the end of this notice to obtain this notice in written form.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us using the information listed at the end of this notice.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your medical information or in response to a request you made to amend or restrict the use or disclosure of your medical information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this notice.

You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your medical information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Mailing Address:

Chief Privacy Officer
Davis Vision - Privacy Office
P.O. Box 1416
Latham, New York 12110-1416

Telephone: **1-800-571-3366**

Fax: **1-866-999-4640**

E-mail: **PRIVACY@DAVISVISION.COM**

Web Site: **WWW.DAVISVISION.COM**

DAVIS VISION™
THE EYECARE ADVANTAGE

MEDICALLY NECESSARY CONTACT LENS PRIOR APPROVAL FORM

SECTION I: PATIENT INFORMATION

Employee/Member Name: _____

Patient's Name: _____

Relationship to Employee/Member: _____

Employee/Member's ID#: _____

SECTION II: NETWORK PROVIDER INFORMATION

Name: _____ Panel No.: _____

Phone No.: _____ Date: _____

Fax No.: _____

SECTION III: SERVICE INFORMATION

I am requesting approval for medically necessary contact lenses for the following reason(s):

Keratoconus ☐ **Other (List:)**_____

_____

Prescription

R: _____

L: _____

VA: R: _____ L: _____

A. Type of lens: _____

B. Diagnosis code(s): _____

C. Fee for fitting and materials: $ _____

FOR DAVIS VISION USE ONLY

Approved By: _____ Date: _____

Denied By: _____ Date: _____

Approved Authorization #: _____

Approved Benefit: _____

_____

Additional Comments: _____

_____

_____

_____

CONFIDENTIALITY NOTE

1. The information contained in this facsimile is confidential and intended for the use of the addressee shown above. If you are neither the intended recipient nor the employer or agent responsible for delivering this message, you are hereby notified that any disclosure, copying, distribution, or taking of any action in reliance on the contents of this telecopied information is strictly prohibited. If you have received this telecopy in error, please notify us by telephone to arrange for its return.
2. **FOR TN PROVIDERS ONLY:** Tennessee state law stipulates that it is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Submit to: Davis Vision, 159 Express Street, Plainview, NY 11803
ATT: Specialty Billing
Toll-free fax: 1-800-584-2329
Any questions, please call 1-800-328-4728 ext. 6811

NEW YORK STATE MANAGED CARE MEMBER COMPLAINT AND APPEALS PROCESS

DEFINITIONS

"Adverse Determination" means a determination by a utilization review agent that an admission, extension of stay, or other health care service, upon review based on the information provided is not medically necessary.

"Appeal" means a request for reconsideration of an adverse determination based upon clinical judgment.

"Company" or "Davis Vision" or "Health Care Plan" shall refer to Davis Vision, Incorporated.

"Emergency Condition" means a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

1.) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy;
2.) serious impairment to such person's bodily functions;
3.) serious dysfunction of any bodily organ or part of such person; or
4.) serious disfigurement of such person.

"External Appeal" is an appeal conducted by an external appeal agent when health care services are denied as not medically necessary, experimental, or investigational.

"Final Adverse Determination" means an adverse determination which has been upheld by a utilization review agent with respect to a proposed health care service following a standard appeal, or an expedited appeal where applicable.

"Insured" or "Member" means a person subject to utilization review.

"Utilization Review" means the review to determine whether health care services that have been provided, are being provided or are proposed to be provided to a patient, whether undertaken prior to, concurrent with or subsequent to the delivery of such services are medically necessary.

APPEAL LEVEL 1

The member, or a health care provider acting on the member's behalf, may file an appeal regarding an adverse determination. The member or health care provider acting on the member's behalf must file an appeal within one hundred and eighty (180) days after the member receives the adverse determination.

Appeals may be made in writing, or by telephone, to Davis Vision. A written appeal may be made in one of several ways. It may be mailed to the following address:

Davis Vision
159 Express Street
Plainview, New York 11083
Attention: Quality Assurance/Patient Advocate Department

Alternatively, Davis Vision members can file an appeal by logging onto our website: www.davisvision.com and clicking on "Contact Us." Once the member is in the "Contact Davis Vision" area, follow the instructions for sending an email to Davis Vision.

Davis Vision members also have access to our toll free number twenty-four (24) hours a day seven days a week to voice concerns and complaints. Our toll free number is: **1 (800) 584-1487**. A Davis Vision Associate will attempt to resolve verbal complaints or concerns.

Upon receipt of an appeal by a Davis Vision Associate, the member is contacted in writing, within five (5) working days to confirm that the appeal was received and is being investigated. It is Davis Vision's policy to make every attempt to contact the member or a designated representative. Contact may include but is not limited to telephone contact, e-mail or U.S. Mail.

A designated Davis Vision Associate reviews the appeal with the member and may request additional information. If within five (5) working days after a member or a health care provider acting on behalf of a member files an appeal, we do not have sufficient information to complete the internal appeal process, we will notify the member and/or health care provider in writing, stating that we cannot proceed with reviewing the appeal unless additional information is provided. The necessary information will be outlined.

Details of the appeal are documented in the member's file. Members are provided with the Associate's name, phone number, department and the estimated time needed to perform the research.

The review committee will include a licensed (peer) health care professional when appeals pertain to clinical decisions. All decisions are reviewed and approved by the Vice President of Professional Affairs, a licensed optometrist.

The investigation may involve contacting the provider or the point of service location to determine the root cause of the concern. When warranted the Regional Quality Assurance Representative (RQAR) or Professional Field Consultant (PFC) will be contacted and a site visit may be scheduled.

Except for emergency condition cases, the determination will be rendered within thirty (30) working days from the filing date for pre-service review decisions and within forty-five (45) working days from the filing date for post-service review decisions, or as otherwise required by state statute. Notice of the appeal decision will be sent to the member and any health care provider or other designee who filed the decision on the member's behalf within two (2) working days after the decision has been made. The notice of appeal decision will:

(1) State in detail in clear, understandable language that the notice constitutes the final adverse determination and the specific reason(s) for our determination and if the adverse decision is upheld on appeal, the clinical rationale for such determination;
(2) State the name, business address, and business telephone number of the designated Company employee or representative who has responsibility for the internal appeal process; and
(3) Include the following information:
(a) That the member or a provider on behalf of the member has a right to file a complaint with the New York State Insurance Department within forty-five (45) days after receipt of the appeal decision,
(b) The Insurance Department's address, telephone number, and website address where an external appeal application can be found,
(c) That if an external appeal application is not sent to the Insurance Department within forty-five (45) days of the final adverse determination from the first level appeal the insured is not eligible for an external appeal.

Failure by Davis Vision to make a determination within the applicable time periods shall be deemed to be a reversal of the initial adverse determination.

APPEAL LEVEL 2

Should Davis Vision uphold a denial, as the result of a Level 1 review, members have the option **either** to request a Level 2 Appeal, **or** to file a complaint with the New York State Insurance Department for external review.

Members do not have to request a second level of internal appeal with Davis Vision. In fact, the forty-five (45) day time limit to file an external appeal begins upon receipt of

the final adverse determination of the Level 1 Appeal and by choosing a Level 2 Appeal the time may expire for you to request an external appeal

If a Level 2 Appeal is chosen it will not include Associates or licensed (peer) health care professionals who were involved in the Level 1 review.

To request a Level 2 Appeal, a member must contact Davis Vision in writing or by telephone within fifteen (15) business days following receipt of the Level 1 appeal decision and consent, in writing, to participate in the Level 2 Appeal. Members must indicate the reason they believe the adverse determination was incorrect. Davis Vision reserves the right to solicit further information from the member or provider and will do so if necessary within five (5) working days after the filing date.

Davis Vision has thirty (30) days, from the date of consent to the Level 2 Appeal in which to complete the Level 2 review. The Vice President of Professional Affairs will review all clinical appeals. A Davis Vision associate and a Regional Quality Assurance Representative (RQAR), a licensed optometrist, who have not have been involved in the initial determination, will review the Level 1 decision. A written decision will be mailed to the member and any health care provider acting on the member's behalf within 5 working of having been made. The decision will include, but not be limited to:

- Outcome of the investigation, and contain a summary stating the nature of the concern and the material facts related to the issue,
- Criteria that was utilized, summary of the evidence, including documentation that was used to support the decision,
- Statement indicating that the decision will be final and binding unless the member appeals in writing or by telephone to the Quality Assurance/Patient Advocacy Department within forty-five (45) days of the date of the notice of the Level 2 decision,
- Copy of the appeals process, if applicable, and
- Name, position, phone number, and department of person(s) responsible for the decision.

Procedures for Expedited Appeals

Davis Vision will provide reasonable access to its clinical peer reviewer within one (1) business day of receiving notice of an expedited appeal and will render a final decision on an appeal that involves an expedited appeal within two (2) business days of receipt of necessary information to conduct such appeal. The member and health care provider will be immediately notified by telephone or facsimile of the need for any required information, if necessary, in order to review the appeal.

For an expedited appeal, within one (1) day after a decision has been orally communicated to the member or health care provider, we will send notice in writing of any appeal decision to: (i) the member; and (ii) the health care provider, if the appeal was filed on behalf of the member by the provider.

An appeal concerning an emergency condition case must include a telephone number where the Company may reach the member or health care provider acting on the member's behalf to communicate the results immediately following review of the appeal.

When an appeal asserts an emergency condition, the Company's Vice President of Professional Affairs, a licensed optometrist, will determine whether an emergency exists.

An expedited appeal will be determined based on circumstances where an adverse determination has been for services that are proposed but have not been delivered, and are continued or extended services, procedures or treatments or additional services for a member undergoing a course of continued treatment prescribed by a provider or in which the provider believes an immediate appeal is warranted.

Expedited appeals that do not result in a resolution satisfactory to the appealing party may be further appealed through the standard appeal process, or through the external appeal process.

FILING COMPLAINTS WITH THE INSURANCE DEPARTMENT

When health services are denied, members must first appeal the denial with Davis Vision, unless both the member AND Davis Vision agree to waive the internal appeal process. The letter agreeing to such a waiver, along with the notice of final adverse determination, must be provided to the member within twenty-four (24) hours of agreement of waiver. If the internal appeal process is exhausted and the denial is upheld on appeal the member may request an external appeal with the New York State Insurance Department within forty-five (45) days from receipt of the final adverse benefit determination from the first level of appeal or a letter from the health care plan waiving the internal appeal process. Eligibility for external review applies only to medical necessity, experimental, or investigational treatment denials. Self-insured plan members are not eligible for the external review process. An External Appeal Form and Application will be enclosed with the written notification to the member of the final adverse benefit determination from Davis Vision.

Such a request must be in writing in accordance with the instructions and in such form as prescribed by the New York State Insurance Department and both the member and their health care provider have the opportunity to submit additional documentation regarding the appeal within the forty-five (45) day period as long as it represents a material change from the documentation upon which the utilization review agent based its denial. Davis Vision will have three (3) business days to consider such documentation and amend or confirm such adverse determination and transmit the clinical standards used to determine medical necessity to the external appeal agent upon receipt of notification of their identity. The external appeal agent shall make a determination with regard to the appeal within thirty (30) days of receipt of request. During this thirty (30) day time period the external appeal agent may request additional information from the member, the member's health care provider and the health care plan in order to make an informed decision. If

such a request is made, the agent shall have up to five (5) additional business days to make a determination.

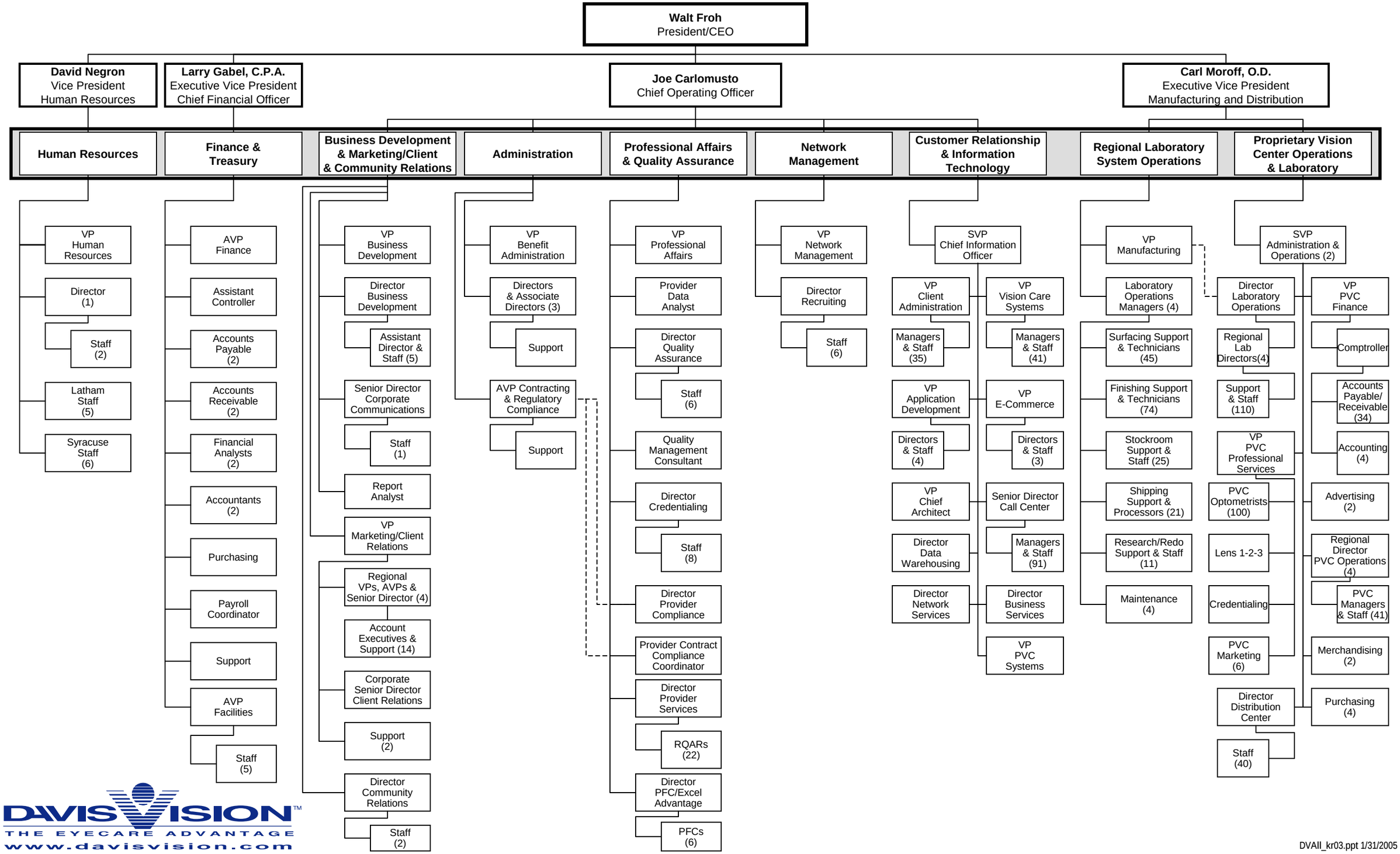
The external appeal agent shall notify the member and health care plan in writing, of the appeal determination within two (2) business days of such determination.

Payment for an external appeal shall be the responsibility of the health care plan however the plan is permitted to charge the member a $50.00 fee which is waived if the member has coverage through Medicaid, Medicare, Child Health Plus, Family Health Plus, or if such fee would be a hardship to them. The fee will be returned to the member if the health care plan's adverse determination is overturned in whole or in part. If the health care plan should reverse a denial that is the subject of an external appeal after assignment to an external appeal agent, but prior to assignment of clinical peer reviewer(s), the health care plan shall be assessed an administrative fee as prescribed by the Commissioner of the Department of Health and Superintendent of the Department of Insurance.

Members may request an expedited external appeal by having their health care provider complete the Attending Physician Attestation in the external appeal application, which can also be found on the insurance department's website, and attest that the member has not yet received the treatment and that a delay in providing the treatment would pose a serious threat to their health. Davis Vision has twenty-four (24) hours to transmit the clinical standards used to determine medical necessity to the external appeal agent upon notification of their identification. Once an appeal is expedited, the external appeal agent must make a decision within three (3) days, even if all the medical information has not been provided to the agent.

In the event an adverse determination is overturned on external appeal, or Davis Vision reverses a denial which is the subject of external appeal, Davis Vision shall provide, or arrange to provide, the health care service(s) which is the basis of the external appeal to the member.

External review decisions are binding upon the parties.



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Thank you for choosing a Davis Vision provider for your vision care services. We hope that you were pleased with your provider visit and our program. Our goal is to provide you with affordable quality services and materials. We would greatly appreciate your responses to the attached survey. It should only take a few moments and it helps us ensure outstanding member satisfaction.

The survey measures your satisfaction with the provider, plan benefits, prescription eyewear and member services. We record the survey responses and respond to any written comments. The results allow us to detect any need for Continuous Quality Improvement and are also a useful way for us to determine how to serve you better.

Davis Vision would also like to remind you that our website and Interactive Voice Response (IVR) system are available twenty-four (24) hours a day, seven (7) days a week to answer many questions about your vision benefits. To check eligibility, review benefits or find a provider you may use the Davis Vision website at **www.davisvision.com**. You may also access our Interactive Voice Response (IVR) system or you can reach our Member Services Center and speak with a representative by calling (toll-free) 1-800-715-9922. Representatives are available from 8 a.m. to 8 p.m. Eastern Time, Monday through Friday and 9 a.m. to 4 p.m. on Saturday.

Thank you for taking the time to share your responses and comments.

Sincerely,

Joseph Carlomusto, ABOC, FNAO
Chief Operating Officer

Joseph Wende, OD
Vice President, Professional Affairs

PATIENT SATISFACTION SURVEY

Please fill in the appropriate box and return to Davis Vision in the U.S. Postage Paid envelope.
****You may also complete this survey on line by accessing our website at www.davisvision.com and choosing the Member Login option.****

PHONE NUMBER DAY:
(☐☐☐) ☐☐☐ - ☐☐☐☐

PHONE NUMBER EVENING:
(☐☐☐) ☐☐☐ - ☐☐☐☐

Please fill in response box entirely, as shown: ☐

	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
Overall Satisfaction:					
Overall, I am satisfied with the vision care received	☐	☐	☐	☐	☐
About Member Services:					
It was easy to obtain member assistance	☐	☐	☐	☐	☐
The Vision Care Member Services Representative was courteous, helpful and knowledgeable	☐	☐	☐	☐	☐
The website was helpful and easy to use	☐	☐	☐	☐	☐
About Your Benefits:					
The value of the vision program was worthwhile	☐	☐	☐	☐	☐
Communication material provided me with the necessary benefit information	☐	☐	☐	☐	☐
About Your Provider:					
The office location was convenient	☐	☐	☐	☐	☐
The office hours were convenient	☐	☐	☐	☐	☐
I obtained an appointment within a reasonable period of time	☐	☐	☐	☐	☐
The office was neat and professional	☐	☐	☐	☐	☐
The waiting time in the provider's office was reasonable	☐	☐	☐	☐	☐
The office staff was friendly and courteous	☐	☐	☐	☐	☐
The time spent with me by the provider and staff was sufficient	☐	☐	☐	☐	☐
The examination was thorough and met my expectations	☐	☐	☐	☐	☐
I am satisfied with the prescription I received	☐	☐	☐	☐	☐
Based on the results of your examination, were you referred for additional testing or specialty care?	**Yes** ☐	**No** ☐			
About Your Eyewear:					
I am happy with the fit and comfort of my eyewear	☐	☐	☐	☐	☐
My eyewear arrived within the time frame indicated	☐	☐	☐	☐	☐

Please offer any additional comments about your experience or offer suggestions for quality improvement:

Please fill in the appropriate box, pertaining to the additional comments: ☐ Positive feedback ☐ Opportunity for Improvement

If you would like a Davis Vision representative to contact you, please check this box: ☐